DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1660M 1/75
(VR A 15(4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77-23188

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Ella | MIDDLE: M | LAST: Adams | 2a. DATE OF DEATH MONTH DAY YEAR: October 1, 1977 |
| 2b. HOUR: 11:10 P.M. | 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: 12-18-97 |
| 6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va. Mineral Cty. | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD. |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Lions Manor Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired ? | 12b. KIND OF BUSINESS OR INDUSTRY: Housewife |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES ☒ NO ☐ | 715 Maryland Ave. |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| John | David | Shipe | Mattie | Lee | Fleek |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT'S NAME, ADDRESS |
|---|---|---|---|
| | | 232-96-5965 | Business Office-Lions Manor Nursing Hm. Seton Drive ext., Cumberland, Md. 21502 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute pneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): cerebral insufficiency & Dementia — year

DUE TO, OR AS A CONSEQUENCE OF (c): ASCVD, severe — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): multiple desease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

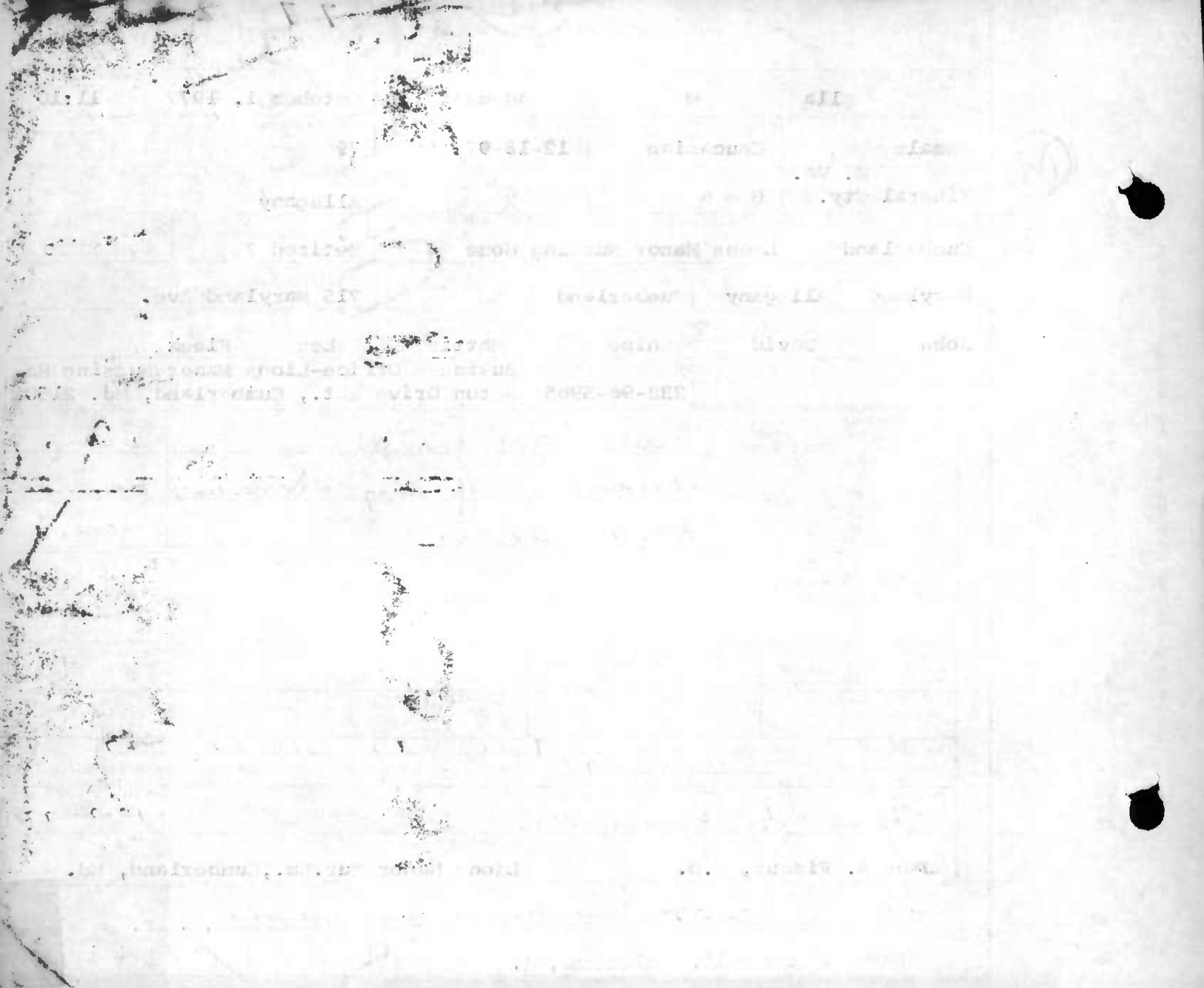
22a. **I certify** that (I) (this hospital) attended the deceased from 9-19 19 77 to 10-1 19 77 that (I) (we) last saw the deceased alive on 10-1 19 77 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Jane A. Fiscus, MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10-2-77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Jane A. Fiscus, M.D. | Lions Manor Nur.Hm., Cumberland, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10-5-1977 | Springfield Cemetery | Springfield W. Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | OCT 7 1977 | Audrey McCready |



FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77-23189

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: MARY | MIDDLE: M. | LAST: ALBRIGHT | 2a. DATE OF DEATH MONTH DAY YEAR: OCTOBER 1, 1977 | 2b. HOUR: 8:35P M | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 4 - 6 - 1896 | 6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): SUMMIT TWP., PA. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGHANY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: HOME | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| PENNA. | SOMERSET | SALISBURY | YES ☒ NO ☐ | GAY ST. |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| SAMUEL | | LINDEMAN | SUSAN | | HUTZELL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 165-50-8692 | FREEMAN ALBRIGHT | GAY ST. SALISBURY, PA. 15558 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Pulmonary Embolus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonectomy surgery

DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma of colon — 9 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): A-V dissociation

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 16 Aug 77 | Carcinoma of colon | YES ☒ NO ☐ | YES ☒ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 3 Oct 77, 19 77, to 1 Oct, 19 77, that (I) (we) last saw the deceased alive on 1 Oct 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Fred W. Miltenberger — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2 Oct 77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. FREDERICK W. MILTENBERGER

22e. ADDRESS: 122 S. CENTRE ST. CUMBERLAND, MD.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 10-4-77 | UNION CEMETERY | MEYERSDALE | SOMERSET | PA. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| GARFIELD F. THOMAS | 101 GRANT ST SALISBURY, PA. 15558 | OCT 6 1977 | Audrey McCready |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1660M 1/75 (VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

77 2319 0 — REG. NO.

1 – FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): First: William — Middle: E. — Last: Baker

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — Month: 10 — Day: 19 — Year: 19 77 — 2b. HOUR: 3:15 AM

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: Month: 4 — Day: 24 — Year: 1907 — 6. AGE (IN YEARS; LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YR.: Months / Days — IF UNDER 24 HRS.: Hours / Min.

2c. DATE PRONOUNCED DEAD: Month: 10 — Day: 19 — Year: 19 77 — 2d. HOUR: 3:15 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA Meyersdale — 7b. CITIZEN OF WHAT COUNTRY?: US of A — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital (DOA) — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Ballistic — 12b. KIND OF BUSINESS OR INDUSTRY: A.B.L.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Cumberland — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: Maron Avenue

14. FATHER'S NAME: First: John — Middle: — Last: Baker — 15. MOTHER'S MAIDEN NAME: First: Rebecca — Middle: — Last: Floto

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WW II — 16b. SOCIAL SECURITY NO.: 214-05-9408 — 17. INFORMANT: Waneda Baker — ADDRESS: Cumberland, MD — Wife

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4109
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden / ---

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 10-19-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic — ADDRESS: Cumberland, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 10-21-77 — 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — 23d. LOCATION CITY OR TOWN: Cumberland — COUNTY: Allegany — STATE: MD

24. FUNERAL DIRECTOR NAME / ADDRESS: James F. Scarpelli, Cumberland, Md. — 25a. DATE REC'D BY REGISTRAR: OCT 24 1977 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 1/75
(VR A 15 (4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23 191

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Michelle MIDDLE: BABY LAST: GIRL BEAL | | | | 2a. DATE OF DEATH MONTH DAY YEAR: SEPTEMBER 30, 1977 | 2b. HOUR: 0134A M |
| 3. SEX: Female | 4. RACE: Cau | 5. DATE OF BIRTH MONTH 9 DAY 30 YEAR 77 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN. 3 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegeny MD | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pa | 13b. COUNTY: √ Somerset | 13c. CITY OR TOWN: Garrett | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: P.O. Box 262 | |
| 14. FATHER'S NAME FIRST: ~~Daivd~~ David MIDDLE: Earnest LAST: Beal | | | 15. MOTHER'S MAIDEN NAME FIRST: Patricia MIDDLE: Kay LAST: Shuck | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. (IF YES, GIVE WAR OR DATES) SOCIAL SECURITY NO. | | 17. INFORMANT: David Beal | ADDRESS: Garrett, Pa. 15542 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
777X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
IMMEDIATE CAUSE (a): Immaturity
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert D Brodell, M.D. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. ROBERT D. BRODELL, M.D. 22e. ADDRESS: 500 GREENE STREET CUMBERLAND, MD. 21502

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 10/1/77 | 23c. NAME OF CEMETERY OR CREMATORY: Reofrmed | 23d. LOCATION CITY OR TOWN: Meyersdale | COUNTY: Som. STATE: Pa. |
| 24. FUNERAL DIRECTOR NAME: M. Ray Leckemby | ADDRESS: Meyersdale, Pa. | 25a. DATE REC'D. BY REGISTRAR: OCT 6 1977 | 25b. REGISTRAR'S SIGNATURE: Kirtley McCready | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

77 23192

REG. NO.

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73
(VR A15 ME (5))

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MARGARET | MIDDLE: ANN | LAST: BECKWITH | 2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH DAY YEAR: 10-2-77 19 | 2b. HOUR: 9:00 P |
| 3. SEX: FEMALE | 4. RACE: NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR: 7 12 1918 | 6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 10-2-77 19 | 2d. HOUR: 9:00 P |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. VA | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X | 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL Hospital---DOA | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEKEEPER | 12b. KIND OF BUSINESS OR INDUSTRY: HOME | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES X NO ☐ | 13e. STREET ADDRESS: 318 FREDERICK ST. CUMB, MD. | |
| 14. FATHER'S NAME FIRST: HARRY | MIDDLE | LAST: BECKWARD | 15. MOTHER'S MAIDEN NAME FIRST: LAURA | MIDDLE | LAST: GREEN |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS: JAMES J. BECKWITH. CUMBERLAND, MD. | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | *** |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO X |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): DEPUTY MEDICAL EXAMINER DATE SIGNED: 10-2-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M.D. ADDRESS: R#9, Cumberland, Maryland 21502

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 10-5-1977 | WOODLAWN CEMETERY | CUMBERLAND, M | ALLEGANY | MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| LEASURE-STEIN FUNERAL HOME | 230 BALTIMORE AVE CUMBERLAND, MD. | OCT 10 1977 | Timothy McCready |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23193

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: VICTOR | MIDDLE: CARL | LAST: BERG | 2a. DATE OF DEATH MONTH DAY YEAR: OCTOBER 30, 1977 | 2b. HOUR: 12:35 PM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: March 26, 1911 | 6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna. | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY, MD. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland, | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Machinist Repr. | 12b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland, | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: Rt. # 1 Bowman's Addition | |
| 14. FATHER'S NAME FIRST: UNKNOWN, | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST: Anna | MIDDLE: M. | LAST: Berg |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes, | (IF YES, GIVE WAR OR DATES): W. W. # 2 | 16b. SOCIAL SECURITY NO.: 217-18-4290 | 17. INFORMANT: Mrs. Mary E. Reynolds | ADDRESS: 19 Valley St. Cumb. Md. 21502 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): widespread metastasis of cell Brain - liver.
DUE TO, OR AS A CONSEQUENCE OF (b): Shock. -
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: a

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ XX | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 10-9, 1977, to 10-30, 1977, that (I) (we) last saw the deceased alive on 10-30, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: J. Mehanna | DEGREE: M. D. | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 10-31-77 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN MEHANNA, M.D. | 22e. ADDRESS: 909-B SETON DRIVE, CUMBERLAND, MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11/2/77 | 23c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens | 23d. LOCATION CITY OR TOWN: LaVale, COUNTY: Allegany STATE: Maryland | |
| 24. FUNERAL DIRECTOR NAME: H. Wayne George | ADDRESS: 202 GREEN ST. CUMBERLAND, MD. 21502 | 25a. DATE REC'D. BY REGISTRAR: NOV 3 1977 | 25b. REGISTRAR'S SIGNATURE: Courtney McCready | |
| GEORGE'S FUNERAL HOME | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 50M 1/76
(VR A 15(4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23194

1. DECEASED NAME (TYPE OR PRINT): FIRST Flora MIDDLE Irene LAST Biggs

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 10 DAY 27 YEAR 77 — 2b. HOUR 5:45 am

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH 6 DAY 7 YEAR 00 — 6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 27 YEAR 77 — 2d. HOUR 5:45a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W.Va. — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: W.Va. — 13b. COUNTY: Mineral — 13c. CITY OR TOWN: Piedmont — 13d. INSIDE CITY LIMITS? YES X NO ☐ — 13e. STREET ADDRESS: 51 Jones Street

14. FATHER'S NAME: FIRST William MIDDLE H. LAST Bryant

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE Linda LAST Mickey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 215-74-4558

17. INFORMANT: Robert Biggs — ADDRESS: Frostburg, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 days

4124

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ASCV Disease — --

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO X

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Benedict Skitarelic M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 10-27-77

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS R#9, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 10/29/77 — 23c. NAME OF CEMETERY OR CREMATORY: Philos — 23d. LOCATION CITY OR TOWN: Westernport COUNTY: Allegany STATE: Md.

24. FUNERAL DIRECTOR NAME: William H. Fredlock — ADDRESS: 31 Jones Street Piedmont, W. Va.

25a. DATE REC'D. BY REGISTRAR: NOV 7 1977 — 25b. REGISTRAR'S SIGNATURE: Lindsay McCready

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23195

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH / ESTIMATED — MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Judy | Ann | Bonner | 10-1-77 19 | 3:05p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Female | White | 1-24-58 | 19 YRS. | | | 10-1-77 19 | 3-05p M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Virginia | USA | NEVER MARRIED [X] | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Machine Operator | Garment |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| W.Va. | Mineral | Ft.Ashby | YES / NO [XX] | Star Route #1 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Alvin | | Bonner | Erika | Magdilena | Bonner Peters |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 170-44-7475 | Alvin Bonner | Same as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Maceration of Brain; Skull Fracture | 7 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Skull fracture | " |
| DUE TO, OR AS A CONSEQUENCE OF (c) | (One car accident) | |

8190

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | 1:40 P.M. 9-24-77 19 | Driver in one car accident |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| NOT WHILE AT WORK [X] | Highway | Rt.#28 Near Ft.Ashby, Mineral, W.Va. |

22a. I certify that I took charge of the remains described above, held on Autopsy [XX] Inspection [XX] Inquiry [XX] and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 10-1-77

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS R#9,

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial C | Oct. 3, 77 | White Oaks | Near Wellersburg, Pa. |

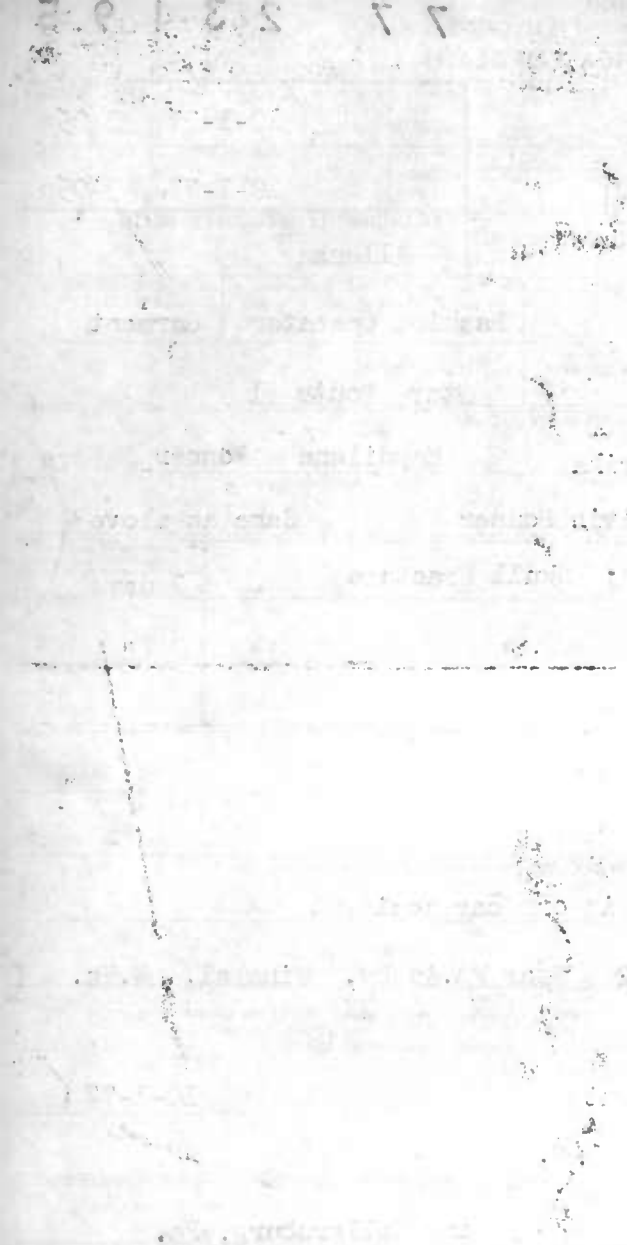
| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| John J. Hafer, Jr. | LaVale, Maryland | OCT 5 1977 | |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23196

1. DECEASED NAME (TYPE OR PRINT): Harriett B. Bradley

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] 10-31 1977 — 2b. HOUR 6p M

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: Apr. 16, 1893 — 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: 10-31 1977 — 2d. HOUR 6p M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Cumberland Nursing Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Instructor — 12b. KIND OF BUSINESS OR INDUSTRY: School

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Frostburg — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 29 Washington St.

14. FATHER'S NAME: Benjamin Bradley — 15. MOTHER'S MAIDEN NAME: Harriet Reese

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 212-38-7327A

17. INFORMANT: Lawrence Bradley — ADDRESS: St. Petersburg, Florida

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — " 

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY 19 YEAR — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 10-31-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic — ADDRESS: RD 9, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Nov. 3, 1977 — 23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Frostburg, Allegany, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Durst Funeral Home, Frostburg, Md. 21532

25a. DATE REC'D. BY REGISTRAR: NOV 8 1977 — 25b. REGISTRAR'S SIGNATURE: Kirkwood McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201**

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23197

1. DECEASED NAME (TYPE OR PRINT): FIRST Robert; MIDDLE Joseph; LAST Brown

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 10 DAY 23 YEAR 77

2b. HOUR 2:05 a M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 7 DAY 30 YEAR 31

6. AGE (IN YEARS LAST BIRTHDAY): 46 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 23 YEAR 77

2d. HOUR 12:05 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital——DOA

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Vice Pres. & Bus. Rep.

12b. KIND OF BUSINESS OR INDUSTRY: Retail Clerks Local # 692

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☐ NO X

13e. STREET ADDRESS: Route #5 Winchester Rd.

14. FATHER'S NAME: FIRST Joseph; MIDDLE Milton; LAST Brown

15. MOTHER'S MAIDEN NAME: FIRST Rose; MIDDLE --; LAST VanMeter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No,

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 217-28-0009

17. INFORMANT: Mrs. Alma C. Brown, ADDRESS Rt. # 5 Box 322-A Cumberland, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY THROMBOSIS, RIGHT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ——

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 10-23-77

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/26/77

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION CITY OR TOWN: Cumberland, COUNTY: Allegany, STATE: Maryland

24. FUNERAL DIRECTOR NAME: George, ADDRESS: H. Wayne George, 202 Greene St. Cumberland, Maryland 21502

25a. DATE REC'D. BY REGISTRAR: OCT 31 1977

25b. REGISTRAR'S SIGNATURE: Shirley McCurdy

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23198

1. DECEASED NAME (TYPE OR PRINT): First: James; Middle: Sloan; Last: Buckley

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ Oct. 3, 1977

2b. HOUR: 2:30 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Oct. 28, 1905

6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.

IF UNDER 1 YR. MONTHS / DAYS

IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Oct. 3, 1977

2d. HOUR: 2:30 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland,

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Farmer,

12b. KIND OF BUSINESS OR INDUSTRY: Farm Owner

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland,

13d. INSIDE CITY LIMITS? YES ☐ NO XX

13e. STREET ADDRESS: Rt. # 4 Brice Hollow Rd.

14. FATHER'S NAME: First: Lemuel; Middle: --; Last: Buckley

15. MOTHER'S MAIDEN NAME: First: Libby; Middle: --; Last: Clower

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No,

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 721-16-9868

17. INFORMANT: Mrs. Susie V. Buckley, ADDRESS: Rt. # 4 Cumb. Md. 21502

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

884X IMMEDIATE CAUSE (a): Skull Fracture; Intracranial Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 31 days

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): (fall at home) — 〃

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 9:00 A.M. 9-2-77 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Fell from roof at home

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: Brice Hollow Road, Cumberland, Allegany, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 10/3/77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M. D. ADDRESS: Rt. # 9 Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/5/77

23c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Gardens

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland, Allegany Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS: H. Wayne George 202 Greene St. Cumberland, Md. 21502

25a. DATE RECD. BY REGISTRAR: OCT 7 1977

25b. REGISTRAR'S SIGNATURE: Mary McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23199

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Maggie — MIDDLE: MAE — LAST: COOK

2a. DATE OF DEATH — MONTH DAY YEAR: 10-16-77

2b. HOUR: 3 45 P.M.

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH — MONTH DAY YEAR: MAY 14 1909

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CUMBERLAND NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR DISTRICT: CUMB

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: P.O. BOX 145.

14. FATHER'S NAME — FIRST: ROBERT — MIDDLE: — LAST: STRAWDERMAN

15. MOTHER'S MAIDEN NAME — FIRST: LOUISE — MIDDLE: — LAST: WHETZEL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

16b. SOCIAL SECURITY NO.:

17. INFORMANT: OLIVER L. COOK — ADDRESS: CUMB. MD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia.

486X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CVA.

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/5/77 to 10/16/77, that (I) (we) last saw the deceased alive on 10/14/1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: T.B. Palmer — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 10/17/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): T.B. HALMOS

22e. ADDRESS: 302 Schley St Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 10/19/77

23c. NAME OF CEMETERY OR CREMATORY: OLD FORGE CEM.

23d. LOCATION — CITY OR TOWN: ACCES — COUNTY: — STATE: MINERAL CO. W. VA.

24. FUNERAL DIRECTOR — NAME: PHILIP B. WENDT — ADDRESS: 121 MEMORIAL AVE. CUMB. MD.

25. DATE REC'D BY REGISTRAR: NOV 3 1977

25b. REGISTRAR'S SIGNATURE: Audrey McCready

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP_____

DHMH - 1660M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23200

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: NOAH | MIDDLE: C. | LAST: COOK | 2a. DATE OF DEATH MONTH DAY YEAR: OCTOBER 12, 1977 | 2b. HOUR: 1915P M | |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH (MO. DAY YR.): Nov. 10, 1892 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.: 84 | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Conductor ret RR | 12b. KIND OF BUSINESS OR INDUSTRY: and Cela nese | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Penna. | Bedford | Hyndman | YES XX NO ☐ | |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Theodore Cook | Mary Ellen Tipton Cook |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW-1 | 214-07-4396 | Mrs. Pearl B. Cook, Hyndman, PA. | 15545 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Advanced metastatic lung & bladder tumor
DUE TO, OR AS A CONSEQUENCE OF (c): bone metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 1621
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from Oct 11 77 Oct. 3 77, to Oct. 12 77, that (I) (we) last saw the deceased alive on Oct 11 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☑ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| [signature] | MD | | 10-13-77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. TERRY WILLIAMS | MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Oct.16,1977 | Hyndman Cemetery | Hyndman, Bedford, Pa. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Harvey H. Zeigler, Hyndman, PA. 15545 | OCT 20 1977 | [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1660M 1/75
(VR A 15 (4))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar of vital statistics after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 1/75
(VR A 15 (4))

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23201

1. DECEASED NAME (TYPE OR PRINT) — FIRST: may — MIDDLE: E. — LAST: Cross

2a. DATE OF DEATH — MONTH: 10 — DAY: 30 — YEAR: 77

2b. HOUR: 10:30 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: March — DAY: 27 — YEAR: 1900

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany — MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE SUCH FACILITY, GIVE STREET ADDRESS): Cumberland Nursing Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic

12b. KIND OF BUSINESS OR INDUSTRY: Housewife

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Westernport — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: Maryland Ave, Westernport

14. FATHER'S NAME — FIRST: James — MIDDLE: — LAST: Chevron

15. MOTHER'S MAIDEN NAME — FIRST: Ida — MIDDLE: — LAST: Harmon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 216-07-7148

17. INFORMANT — ADDRESS: Mrs John Smith Orchard St. Keyser, W. Va

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Heart failure

DUE TO, OR AS A CONSEQUENCE OF (b): CVD.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumonia.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 76, to 10/30 19 77, that (I) (we) last saw the deceased alive on 10/29 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: B Palmer — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10/30/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): B Palmer

22e. ADDRESS: 302 Schlegel St. Cumberland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/1/77

23c. NAME OF CEMETERY OR CREMATORY: Philos

23d. LOCATION — CITY OR TOWN — COUNTY — STATE: Westernport Allegany Md.

24. FUNERAL DIRECTOR — NAME AND ADDRESS: Boals Funeral Service Westernport, Md.

25a. DATE REC'D. BY REGISTRAR: NOV 3 1977

25b. REGISTRAR'S SIGNATURE: Anthony McCready

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

77 23202
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | |
|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | LEORA / RUTH / CROWE |
| 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 28, 1977 |
| 2b. HOUR | 12.50A M |
| 3. SEX | Female |
| 4. RACE | White |
| 5. DATE OF BIRTH MONTH DAY YEAR | July 25, 1909 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 68 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | |
| IF UNDER 24 HRS. HOURS / MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Penna. |
| 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | ALLEGANY COUNTY MD. |
| 10. CITY OR TOWN OF DEATH | Cumberland |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) | SACRED HEART HOSPITAL |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Sales Clerk |
| 12b. KIND OF BUSINESS OR INDUSTRY | Clothing |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE / 13b. COUNTY / 13c. CITY OR TOWN | Maryland / Allegany / Frostburg |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | |
| 13e. STREET ADDRESS | Rt. 40 West |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Ira / Johnson |
| 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Susie / Frickie |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | No |
| 16b. SOCIAL SECURITY NO. | 194-03-0096 |
| 17. INFORMANT ADDRESS | Mrs. Wanda Anderson, Saratoga, Cal. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinomatosis intraabdominal | 9 months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinoma of colon | 2 1/2 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 10-4, 19 77, to 10/28, 19 77, that (I) (we) last saw the deceased alive on 10/27, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE | Andrew Stasko M.D. | DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ |
| 22c. DATE SIGNED | 10/28/77 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | ANDREW STASKO M. D. | |
| 22e. ADDRESS | 924 SETON DRIVE CUMBERLAND MD. | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | |
| Burial | Oct. 31, 1977 | Greenville Cemetery | Pocahontas, Somerset, Pa. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | DURST FUNERAL HOME 57, FROST AVENUE FROSTBURG MD. | 25a. DATE REC'D. BY REGISTRAR | NOV 3 1977 | 25b. REGISTRAR'S SIGNATURE Kathryn McCready |

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77 23203

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Lavina — MIDDLE: — LAST: Davidson

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH: Oct. DAY: 24, YEAR: 77 — 2b. HOUR: 6:19 A.M.

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH Nov. DAY 2, YEAR 1898 — 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Oct. DAY 24, YEAR 19 77 — 2d. HOUR: 6:19 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland, — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): D. O. A. Memorial Hosp. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Telephone Opr. — 12b. KIND OF BUSINESS OR INDUSTRY: Hotels,

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Cumberland, — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 14 Decatur St.

14. FATHER'S NAME — FIRST: Charles — MIDDLE: -- — LAST: Prince

15. MOTHER'S MAIDEN NAME — FIRST: Bertha — MIDDLE: -- — LAST: Christey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No, — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO. —

17. INFORMANT — ADDRESS: Mrs. Mary K. Ritter, 6614 Mayfair Dr. Falls Church, Va.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | --- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: Oct. 24, 1977

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M. D. — ADDRESS: Rt. # 9 Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 10/26/77 — 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park, — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland, Allegany Maryland

24. FUNERAL DIRECTOR NAME: H. Wayne George — ADDRESS: 202 Greene St. Cumberland, Md. 21502 — 25a. DATE REC'D. BY REGISTRAR: OCT 31 1977 — 25b. REGISTRAR'S SIGNATURE: Timothy McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME(5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23204

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): DOROTHY ELLEN DECKER
2a. DATE OF DEATH: OCTOBER 27, 1977
2b. HOUR: 6:35A M
3. SEX: Woman Female
4. RACE: White
5. DATE OF BIRTH: July 13 1910
6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.
IF UNDER 1 YEAR: MONTHS, DAYS
IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY, MD.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Co-Owner
12b. KIND OF BUSINESS OR INDUSTRY: Ladies Wear Store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: La Vale
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 1125 Braddock Road

14. FATHER'S NAME: Robert Donnelly
15. MOTHER'S MAIDEN NAME: Ellen Fitzwilliam
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Mrs. Vivian Keech, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
#360
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10/9/77

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/5 19 77 to 10/27 19 77, that (I) (we) last saw the deceased alive on 10/24 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: N Espina, MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/27/77
22d. PHYSICIAN'S NAME (TYPE OR PRINT): N RENATO ESPINA, M.D.
22e. ADDRESS: 907 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10=29-1977
23c. NAME OF CEMETERY OR CREMATORY: St.Marys Cemetery
23d. LOCATION CITY OR TOWN: Cumberland, COUNTY: Allegany, STATE: Md.

24. FUNERAL DIRECTOR NAME: SCARPELLI FUNERAL HOME
ADDRESS: 108 VIRGINIA AVE. CUMBERLAND, MD. 21502
25a. DATE REC'D. BY REGISTRAR: OCT 31 1977
25b. REGISTRAR'S SIGNATURE: Kathryn McCready

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23205

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | CLETUS L. DELOZIER | | | 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 28, 1977 |
| 2b. HOUR | 2:05A M | | | | |
| 3. SEX | Male | 4. RACE | Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR | June 14, 1904 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Allegany County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Painter |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Penna. | Bedford | Hyndman | YES [X] NO [ ] | |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Edward DeLozier | Carrie Bruner |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | | 220-10-7588 | Mrs. Mary DeLozier, Hyndman, Pa. | 15545 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinoma (R) lung | 1 Month |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Multiple Metastasis | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/24/77, 19 77, to 10/28/77, 19 77, that (I) (we) lost saw the deceased alive on 10/28/77, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 10/28/1977 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. A. SIVAN PILLAI, MD. | 915 SETON DRIVE CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | October 30, 1977 | Hyndman Cemetery | Hyndman, Bedford Co. Pa. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Harvey H. Zeigler, Hyndman, Pa. 15545 | NOV 2 1977 | [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23206

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Arthur; MIDDLE: Clifton; LAST: Eshelman

2a. DATE OF DEATH — MONTH DAY YEAR: October 16, 1977

2b. HOUR: 9:40 M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH DAY YEAR: 04-01-80

6. AGE (IN YEARS LAST BIRTHDAY): XX 97 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Bedford Cty, Pa.

7b. CITIZEN OF WHAT COUNTRY?: U S A

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Lions Manor Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Store Owner

12b. KIND OF BUSINESS OR INDUSTRY: Grocery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS: 16 Greene St.

14. FATHER'S NAME — FIRST: George; MIDDLE: Washington; LAST: Eshelman

15. MOTHER'S MAIDEN NAME — FIRST: Rachel; MIDDLE: ; LAST: Ritchie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No,

(IF YES, GIVE WAR OR DATES): No,

16b. SOCIAL SECURITY NO.: 214-36-6935

16c. INFORMANT'S MAILING ADDRESS (STREET OR R.F.D., CITY OR TOWN, STATE): Business Office-Cumberland, Md. 21502 Lions Manor Nursing Home-Seton Dr. ext.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 4123 Pulmonary Embolism probable — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure — months

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anemia; Renal insufficiency; Pulmonary Fibrosis

19a. DATE OF OPERATION: X

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): X

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-7, 1977, to 10-16, 1977, that (I) (we) last saw the deceased alive on 10-16 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jane A. Fiscus, MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10/16/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jane A. Fiscus, M.D.

ADDRESS: Lions Manor Nursing Home Seton Drive ext., Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Oct. 19, 1977

23c. NAME OF CEMETERY OR CREMATORY: Everett Cemetery

23d. LOCATION CITY OR TOWN, COUNTY, STATE: Everett, Bedford, Penna.

24. FUNERAL DIRECTOR NAME, ADDRESS: H. Wayne George, 202 Greene Street, Cumb. Md.

25a. DATE REC'D. BY REGISTRAR: OCT 21 1977

25b. REGISTRAR'S SIGNATURE: Audrey McCready

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 1/75 (VR A 15 (4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

77 23207
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Louisa | MIDDLE: Caroline | LAST: Francolini | 2a. DATE OF DEATH MONTH DAY YEAR: October 05, 1977 | 2b. HOUR: 1:17 PM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 03-03-40 | 6. AGE (IN YEARS LAST BIRTHDAY): 37 YRS | IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany Co., MD. | |
| 10. CITY OR TOWN OF DEATH: Cumberland, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 103 Sunset Drive |
| 14. FATHER'S NAME FIRST: JOHN | MIDDLE: BENJAMIN | LAST: JESSON | 15. MOTHER'S MAIDEN NAME FIRST: SUSANNAH | MIDDLE: | LAST: BOWERS |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 210-30-5085 | 17. INFORMANT: ROBERT P. FRANCOLINI | ADDRESS: CUMB., MD. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 years

181X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| X | | | |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| X | | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION. STREET / CITY OR TOWN / COUNTY / STATE |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: George Breeza | DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X] | 22c. DATE SIGNED: 10/5/77 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE BREEZA | 22e. ADDRESS: ~~SACRED HEART~~ HEMORRHAGE SACRED HEART HOSP. CUMB., MD. | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 10/10/77 | 23c. NAME OF CEMETERY OR CREMATORY: GLENWOOD MEM. GARDENS | 23d. LOCATION CITY OR TOWN: BROOKHAVEN / COUNTY / STATE: PA |
| 24. FUNERAL DIRECTOR NAME: PHILIP B. WENDT | ADDRESS: 121 MEMORIAL AVE., CUMB., MD. | 25a. DATE REC'D. BY REGISTRAR: OCT 13 1977 | 25b. REGISTRAR'S SIGNATURE: [signature] |

BP_____

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

77 23208
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY | MIDDLE: JOANN | LAST: GAUMER | 2a. DATE OF DEATH MONTH DAY YEAR: OCTOBER 20, 1977 | 2b. HOUR: 5:25 AM | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: March 6 1936 | 6. AGE (IN YEARS LAST BIRTHDAY): 41 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housekeeper | 12b. KIND OF BUSINESS OR INDUSTRY: ----- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 822 Shawnee Avenue | |
| 14. FATHER'S NAME FIRST: Joseph | MIDDLE: J | LAST: Knight | 15. MOTHER'S MAIDEN NAME FIRST: Mabel | MIDDLE: E | LAST: Hausman |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 220-32-4737 | 17. INFORMANT: Curtis E. Gaumer | ADDRESS: 822 Shawnee Ave Cumberland, Md | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Coma - Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Ca of heart to liver, bone -
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 10-16, 1977, to 10-19, 1977, that (I) (we) last saw the deceased alive on 10-19-77 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] | DEGREE: M.D. | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 10-20-77 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN MEHANNA M.D. | 22e. ADDRESS: 909-B SETON DRIVE, CUMBERLAND, MD 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Oct 22, 1977 | 23c. NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cem | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland Allegany Maryland | |
| 24. FUNERAL DIRECTOR NAME: SILCOX-FUNERAL HOME Merritt | ADDRESS: 404 DECATEUR ST. CUMB. MD. | 25a. DATE REC'D BY REGISTRAR: OCT 24 1977 | 25b. REGISTRAR'S SIGNATURE: [signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23209

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | CLYDE / F. / GILL SR. | 2a. DATE OF DEATH MONTH DAY YEAR | OCT. 5, 1977 |
| 2b. HOUR | 11:45A M | | |
| 3. SEX | MALE | 4. RACE | WHITE |
| 5. DATE OF BIRTH MONTH DAY YEAR | SEPT. 25 1910 | 6. AGE (IN YEARS LAST BIRTHDAY) | 67 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | W. VA. | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | ALLEGANY MD. |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | MEMORIAL HOSPITAL |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | TAX SERVICE | 12b. KIND OF BUSINESS OR INDUSTRY | ACCOUNTING |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MARYLAND | 13b. COUNTY | ALLEGANY |
| 13c. CITY OR TOWN | CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS 481 BALTIMORE AVE. |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | JOHN / A. / GILL | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | TENCIE / STECKLER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 216-07-7149 | 17. INFORMANT | CLYDE F. GILL, JR. ADDRESS CUMB., MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Bronchopneumonia. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

485X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary embol. CAD.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10/4 19 77 to 10/5 19 77 that (I) (we) last saw the deceased alive on 10/5 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE T.J. Palmer DEGREE MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE SIGNED 10/9/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SAMUEL M. JACOBSON

22e. ADDRESS 50 PERSHING ST. CUMBERLAND, MD.

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | BURIAL | 23b. DATE | 10/8/77 |
| 23c. NAME OF CEMETERY OR CREMATORY | ST. LUKE'S CEM. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | CUMBERLAND ALLEG. MD. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | PHILIP B. WENDT 121 MECH. AVE. CUMB., MD. | 25a. DATE REC'D. BY REGISTRAR | OCT 13 1977 |
| 25b. REGISTRAR'S SIGNATURE | Courtney Kay Grady | | |

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

77 23210
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | BESSIE ELIZABETH GOLDSWORTHY | 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 8, 1977 |
| 2b. HOUR | 5:18 PM | | |
| 3. SEX | Female | 4. RACE | White |
| 5. DATE OF BIRTH MONTH DAY YEAR | August 25, 1893 | 6. AGE (IN YEARS LAST BIRTHDAY) | 84 YRS |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | U. S. A. |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | Allegany MD. |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | MEMORIAL HOSPITAL |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Housewife & Clerk | 12b. KIND OF BUSINESS OR INDUSTRY | Shoe Store |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | 13b. COUNTY | Allegany |
| 13c. CITY OR TOWN | Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | |
| 13e. STREET ADDRESS | 718 Columbia Ave. | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | George -- Williams | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Elizabeth -- Walters |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No, | (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | Mr. George O. Schutz, 718 Columbia Ave. Cumberland, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIO - RENAL FAILURE | 2 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | HEPATIC + GEN'L ABDOMINAL METASTASIS | months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | ADENOCARCINOMA OF ASCENDING COLON, CECUM | Approx 6-12 mos. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c): HYPOPROTEINEMIA

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | July 6, 1977 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | CARCINOMA OF COLON |
| 20a. AUTOPSY? YES ☐ NO ☒ | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from Oct 6, 19 77, to Oct 7, 19 77, that (I) (we) last saw the deceased alive on Oct 7, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | | |
|---|---|---|---|---|
| 22b. SIGNATURE | Richard Schindler | DEGREE | M.D. | 22c. DATE SIGNED 10/10/77 |
| ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | DR. RICHARD SCHINDLER-PA | 22e. ADDRESS | 69 GREENE ST, CUMBERLAND, MD. | |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 10/11/77 | 23c. NAME OF CEMETERY OR CREMATORY | Frostburg Memorial Pk. |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Frostburg, Allegany Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | H. Wayne George 202 Greene St. Cumberland, Md. 21502 | 25a. DATE REC'D. BY REGISTRAR | OCT 17 1977 | 25b. REGISTRAR'S SIGNATURE | Kathy McCurdy |

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23211

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | KATHLEEN | JONES | GOUGH | |
| 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 7-1977 | | | 2b. HOUR 1:00PM |
| 3. SEX | Female | | | |
| 4. RACE | White | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR | Aug. 10, 1919 | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 58 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | | |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | ALLEGANY CO, MD. | | | MD. |
| 10. CITY OR TOWN OF DEATH | Cumberland | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | SACRED HEART HOSPITAL | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Machine Operator | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | Textile | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Allegany | Pinto | YES ☐ NO ☒ | Yoders Trailer Court |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Charles Jones | Sarah Quinn |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| no | | | Mrs. Greta A. Barncord, Florida, Daughter |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinomatosis Intra abdominal | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinoma of colon | 3mo |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 9/5, 19 77, to 10/7, 19 77, that (I) (we) last saw the deceased alive on 10/7, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Andrew Stasko MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/8/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| ANDREW STASKO, MD. | SETON DRIVE CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10-10-1977 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCARPELLI FUNERAL HOME, CUMBERLAND, MD. 21502 | OCT 13 1977 | Kathryn McCready |

BP

DHMH - 1650M 1/76
(VR A 15 (4))

77 2321

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23212

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Anna MIDDLE: Nora LAST: Gray | | 2a. DATE OF DEATH MONTH DAY YEAR: October 18, 1977 | 2b. HOUR: 4:45 A.M. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: May 10, 1890 | 6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD. |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Allegany County Infirmary | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cook | 12b. KIND OF BUSINESS OR INDUSTRY: Restaurant |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Frostburg | YES ☒ NO ☐ | 11 Bowery St. |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Louis | | Spiker | Maggie | | Thomas |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 381-30-5035A | Mr. Thomas James, Frostburg, Md. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute Coronary occlusion | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Sclerosis | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic Heart Disease | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus. Senile Psychosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from Sept. 23, 19 77, to Oct. 18, 19 77, that (I) (we) last saw the deceased alive on Oct. 17, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☒ | 22c. DATE SIGNED |
|---|---|---|---|
| John A Topper | MD | | 10 18 77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| John A Topper | Memorial Hospital, Cumberland, Maryland 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | Oct. 20, 1977 | Laurel Hill Cemetery | Barton, Allegany, Md. |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Durst Funeral Home, Frostburg, Md. 21532 | OCT 24 1977 | Tiffany McCready |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 232 13

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Frederick; MIDDLE: W; LAST: Green

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ]: MONTH 10 DAY 13 YEAR 19 77

2b. HOUR: 1-PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 1 DAY 24 YEAR 1903

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.

IF UNDER 1 YR. — MONTHS: DAYS:

IF UNDER 24 HRS. — HOURS: MIN.:

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 13 YEAR 1977

2d. HOUR: 1-PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Coal Miner

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: Allegany

13c. CITY OR TOWN: Gilmore

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: Rural Route, Lonaconing

14. FATHER'S NAME — FIRST: Horace; MIDDLE: Joseph; LAST: Green

15. MOTHER'S MAIDEN NAME — FIRST: Mary; MIDDLE: Alice; LAST: Barnard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: Frances Patton, Westernport, Md. (Daughter)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2):

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.):

21f. LOCATION — STREET: CITY OR TOWN: COUNTY: STATE:

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 10/13/1977

EXAMINER'S NAME (TYPE OR PRINT): Benidict Skitarelic ADDRESS: Rt. 9 Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/16/1977

23c. NAME OF CEMETERY OR CREMATORY: Greens Cemetery

23d. LOCATION CITY OR TOWN: (Rural) Lonaconing COUNTY: Garrett STATE: MD.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Eichhorn Funeral Home, Lonaconing, Md.

25a. DATE REC'D. BY REGISTRAR: OCT 18 1977

25b. REGISTRAR'S SIGNATURE: Kathryn McCarty

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23214

1. DECEASED NAME (TYPE OR PRINT): FIRST Aden MIDDLE J. LAST Hanna

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR 10-6-77 — 2b. HOUR 7a M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH DAY YEAR Oct.12,1905 — 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR 10-6-77 — 2d. HOUR 2p M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Clarysville — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Clarysville Inn — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Security Guard — 12b. KIND OF BUSINESS OR INDUSTRY: Motor Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Virginia — 13b. COUNTY: Norfolk — 13c. CITY OR TOWN: Norfolk — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: Hague Towers

14. FATHER'S NAME: FIRST William MIDDLE LAST Hanna

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE Ann LAST Harris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): W.W. 2 — 16b. SOCIAL SECURITY NO.: 225-07-8373 — 17. INFORMANT ADDRESS: Mrs. Elizabeth Middleton, Frostburg Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot of Head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b): (Self Inflicted)
DUE TO, OR AS A CONSEQUENCE OF
(c):
955X
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify thot I took charge of the remoins described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ ond in my opinion death resulted from: Noturol causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined monner ☐,

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 10-6-77

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic,M.D. ADDRESS R#9,Cumberland,Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Oct.9,1977 — 23c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park — 23d. LOCATION CITY OR TOWN COUNTY STATE: Frostburg, Alleg., Md.

24. FUNERAL DIRECTOR NAME ADDRESS: Durst Funeral Home, Frostburg, Md. 21532 — 25a. DATE REC'D. BY REGISTRAR: OCT 14 1977 — 25b. REGISTRAR'S SIGNATURE: Kathryn McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23215

1. DECEASED NAME (TYPE OR PRINT): FIRST Wesley; MIDDLE Kline; LAST Hartman

2d. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Oct. 14, 19 77 — 2b. HOUR 1:15 P.M.

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH Apr. DAY 25, YEAR 1915 — 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: Oct. 14, 19 77 — 2d. HOUR 1:15 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va. — 7b. CITIZEN OF WHAT COUNTRY? U. S. A. — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland, — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): D. O. A. Sacred Heart Hosp. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Trackman, — 12b. KIND OF BUSINESS OR INDUSTRY: Chessie Rwy.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Cresaptown, — 13d. INSIDE CITY LIMITS? YES [ ] NO [XX] — 13e. STREET ADDRESS: Craddock Rd. Rt. # 5

14. FATHER'S NAME: FIRST Howard; MIDDLE --; LAST Hartman

15. MOTHER'S MAIDEN NAME: FIRST Virginia; MIDDLE B.; LAST Ours

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No, (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 233-09-0313

17. INFORMANT: Mrs. Iva C. Hartman ADDRESS: Rt. # 5 Cresaptown, Md 21502

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [XX] Inquiry [XX], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: Oct. 14, 1977

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M. D. ADDRESS: Rt. # 9 Balto. Pike, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 10/17/77 — 23c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens — 23d. LOCATION CITY OR TOWN: LaVale COUNTY: Allegany STATE: Maryland

24. FUNERAL DIRECTOR NAME: H. Wayne George ADDRESS: 202 Greene St. Cumberland, Md. 21502 — 25a. DATE REC'D. BY REGISTRAR: OCT 20 1977 — 25b. REGISTRAR'S SIGNATURE: Audrey McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23216

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| VIRGIL | LENWOOD | HARTSOCK | OCTOBER 9, 1977 | 2:00P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | Feb 5 1917 | 60 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | ALLEGANY COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | SACRED HEART HOSPITAL | Supt of Carpenters | Const Co |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Corriganville | YES ☐ NO ☒ | |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Virgil | L | Hartsock, Sr | Edna | | Richardson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWII | 217-10-7325 | Mrs. Elsie Hartsock | Corriganville, Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA Larynx — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| George Breza MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/10/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. GEORGE BREZA | SETON DRIVE, CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Oct 12, 1977 | Sunset Memorial Park | Cumberland Allegany Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SILCOX-MERRITT FUNERAL SERVICE, 404 DECATUR ST. CUMBERLAND, MD. 21502 | OCT 17 1977 | Anthony McGlody |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))

VIRGIL LENWOOD HARTSOCK OCTOBER 3, 1977 2:00P

ALLEGANY COUNTY

SACRED HEART HOSPITAL

SILCOX-HERRITT FUNERAL SERVICE, 404 DECATUR ST.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23217

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ADA — MIDDLE: P. — LAST: HENDERSHOT
2a. DATE OF DEATH — MONTH DAY YEAR: OCTOBER 30, 1977
2b. HOUR: 2020 PM
3. SEX: Woman
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: 2 6 1900
6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: US of A
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ YY
9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 636 East First Street

14. FATHER'S NAME — FIRST MIDDLE LAST: Thomas Mc Cusker
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Florence Mc Cusker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES):
17. INFORMANT — ADDRESS: Harold L. Hendershot Cumberland, MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardio - Pulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO, OR AS A CONSEQUENCE OF (b): Acute infection UR. T. — 2 days
DUE TO, OR AS A CONSEQUENCE OF (c): A S C V D — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/29, 19 77, to 10/30, 19 77, that (I) (we) last saw the deceased alive on 10/30, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: J K Elder — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 11/1/77
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. THADDEUS H ELDER
22e. ADDRESS: MEMORIAL HOSPITAL MEDICAL BUILDING

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 11-2-77
23c. NAME OF CEMETERY OR CREMATORY: Buck Valley M.E. Cem.
23d. LOCATION — CITY OR TOWN COUNTY STATE: Buck Valley, PA
24. FUNERAL DIRECTOR — NAME ADDRESS: James F. Scarpelli Cumberland, MD
25a. DATE REC'D. BY REGISTRAR: NOV 7 1977
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

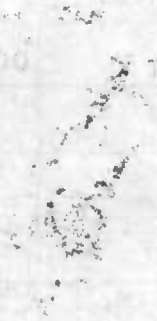
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

BP

DHMH · 16 60M 1/75
(VR A 15 (4))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23218

| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|
| EDWARD / HENSELL | OCTOBER 8, 1977 | 10:00P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | Apr. 20, 1897 Unknown | 80 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Md. | USA | | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD | MEMORIAL HOSPITAL | Miner Ret. | Coal |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Allegany | Mt. Savage | YES ☐ NO ☒ | None |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Charles / Hensell | Annie / Shoemaker |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | 217-05-3513A | Hospital Records |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Severe obstructive pulmonary disease
DUE TO, OR AS A CONSEQUENCE OF (c) G.I. bleeding probably secondary
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
5193
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/10/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. AMADO P. TORRES | MEMORIAL MEDICAL BLDG, CUMBERLAND, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Oct. 14, 1977 | Frostburg Mem. P | Frostburg Allegany Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| William G. Kight | Cumberland, Md. | OCT 17 1977 | Kathryn McCready |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1660M 1/75
(VR A 15 (4))

1

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

77 23219
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| RUTH | MARGARET | HOWARD | OCTOBER 15, 1977 | 8:10A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| ~~Woman~~ Female | White | Sept. 24, 1899 | 78 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| PA | Us of A | | ALLEGANY COUNTY, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | SACRED HEART HOSPITAL | Housewife | Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Allegany | Oldtown | YES ☐ NO ☒ | R.D. 1, Oldtown, MD |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| Lawrence Amsler | Sarah Armstrong |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Herbert Howard | Oldtown, MD |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☑ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 10/4, 19 77, to 10/15, 19 77, that ~~I~~ (we) last saw the deceased alive on 10/14, 19 77, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we) did~~ (did not) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 22c. DATE SIGNED |
|---|---|---|
| W. Hijab, MD for Dr. C. Vincent | | 10/15/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| WALLY HIJAB | 909 A Seton Drive Cumberland |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 10-17-77 | Beahms Chapel Cem. | Luray, VA |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SCARPELLI FUNERAL HOME | 108 VIRGINIA AVE. CUMBERLAND, MD. 21502 | OCT 19 1977 | Kathryn McCready |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23220

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Gladys | J. | Hughes | 10/9/77 | 3:45 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Female | White | 6/3/87 | 90 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Mt. Savage, MD | U.S. | | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frostburg | Frostburg Comm. Hospital | Unemployed | - |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Mt. Savage | YES ☒ NO ☐ | Rt. 1, Box 31 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Joseph | | Crowe | Virginia | - | Kirby |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 217-54-6525 | Mary Lantz-grand-daughter, Mt. Savage, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF (b) ACVD - chronic — 25 yrs +/-

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

H124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Malignant Neoplasm of rt. breast

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| None | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 08-26, 1977, to 10-9, 1977, that (I) (we) last saw the deceased alive on 10-09 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| Martin M. Rothstein M.D. | M.D. | | 10/10/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Martin M. Rothstein M.D. | 48 Broadway - Frostburg, Md. 21532 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | Oct. 12, 1977 | St. George Cemetery | Mt. Savage, | Allegany, | Md. |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Durst Funeral Home, Frostburg, Md. 21532 | OCT 14 1977 | Kirtley McCready |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77 (VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23221

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| =Joseph | | Hutchinson | 10-25-77 | 9:00a |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS) (LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | Dec. 22 1917 | 59 YRS. | | | 10=25-77 | 9:00a |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital--DOA | Maintenance | State Hosp. |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | | 1003 Kentucky Avenue |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Unknown | | | Unknown | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 212-38-0068 | Mary C. Hutchinson | Cumberland, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary Occlusion | Sudden |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Sclerosis | --- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 10-25-77

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS #R#9 Cumberland, Maryland 21502

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10/28/77 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| F Wendt Funeral | Cumberland, Maryland | NOV 3 1977 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 77 23222

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| GARLAND | LEON | JOHNSTON | 10-29-77 | 6:55PM M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS: HOURS, MIN |
| Male | White | Nov 25 1905 | 71 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Virginia | U.S.A. | | ALLEGANY CO., MD. MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cumberland | SACRED HEART HOSPITAL | Retired Manager | Potomac Edison Co | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Allegany | LaVale | YES ☐ NO ☒ | 1233 Braddock Road | |
| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
| Benjamin | F | Johnston | Nellie | Vernon | Custer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | |
| No | | 214-10-5357 | Mrs. Judith Soteropoulos | 2415 E. Geneva Dr Tempe, Arizona | |

**MEDICAL CERTIFICATION**

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) C.H.D.

DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

C.O.P.D. (severe) Ca of the rectum s/p resection & permanent colostomy.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| | | | |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I **certify** that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE C.J. Vincent M.D. | DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CLARENCE J. VINCENT, M.D. | 22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, M.D. 21502 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Nov 2/77 | 23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem Gardens | 23d. LOCATION CITY OR TOWN LaVale COUNTY Allegany STATE Maryland | |
| 24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL HOME | ADDRESS 404 DECATUR ST., CUMBERLAND, MD. 21502 | 25a. DATE REC'D. BY REGISTRAR NOV 2 1977 | 25b. REGISTRAR'S SIGNATURE Timothy McCready | |

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))

77 2 3 2 2 2 C

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23223

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN MIDDLE: GILBERT LAST: KIGHT | 2a. DATE OF DEATH MONTH DAY YEAR: 10-28-77 | 2b. HOUR: 4:10PM | |
| 3. SEX: Male | 4. RACE: Cau | 5. DATE OF BIRTH MONTH DAY YEAR: May 11, 1881 | 6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va. | 7b. CITIZEN OF WHAT COUNTRY?: usa | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY CO., MD. MD. |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Tire |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pa. | 13b. COUNTY: Bedford | 13c. CITY OR TOWN: Centerville | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: RD # 3 Bedford, Pa. |
| 14. FATHER'S NAME FIRST: Gilbert MIDDLE: LAST: Kight | | 15. MOTHER'S MAIDEN NAME FIRST: Susan MIDDLE: Adams LAST: Kight | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.: 216-18-1896 | 17. INFORMANT: Edgar Kight ADDRESS: Baltimore, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of prostate - metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year
185X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNOFFRLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on 10-28 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

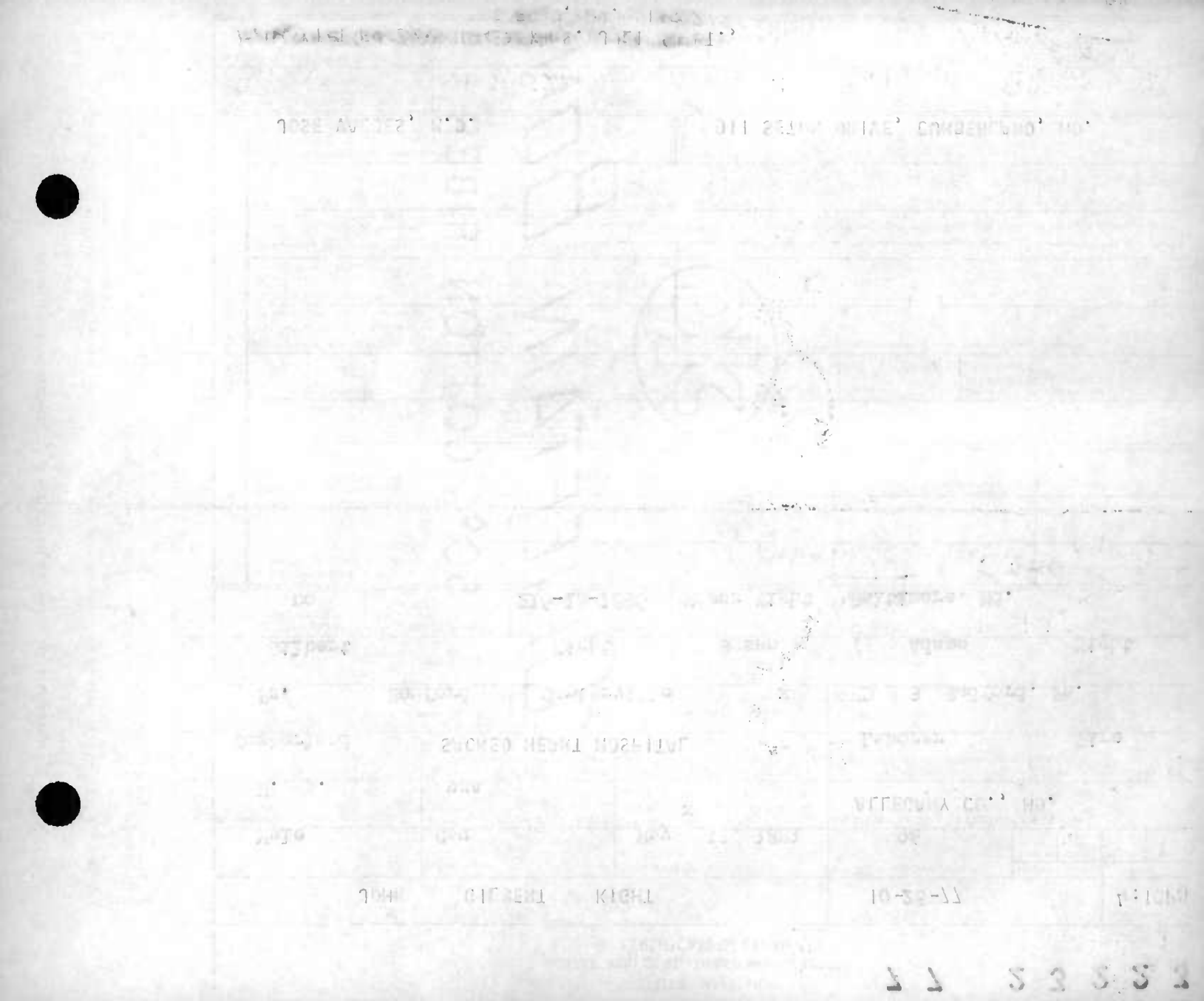
22b. SIGNATURE: Michael Valdes MD (Courtesy for) — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 10/29/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOSE VALDES, M.D. — 22e. ADDRESS: 911 SETON DRIVE, CUMBERLAND, MD.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Oct 31, 1977 | 23c. NAME OF CEMETERY OR CREMATORY: UNION Cemetery | 23d. LOCATION CITY OR TOWN: Centerville COUNTY: Bedford STATE: Pa. | |
| 24. FUNERAL DIRECTOR: Hollyday George H. ADDRESS: 202 Green St. Cumberland, Maryland 21502 BEDFORD, | | | 25a. DATE REC'D. BY REGISTRAR: NOV 8 1977 | 25b. REGISTRAR'S SIGNATURE: Tiffany Eichenly |

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

77 23224
REG. NO.

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

| | |
|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Leonard G. Klink |
| 2a. DATE OF DEATH MONTH DAY YEAR | October 15, 1977 |
| 2b. HOUR | M |
| 3. SEX | Male |
| 4. RACE | White |
| 5. DATE OF BIRTH MONTH DAY YEAR | April 7, 1895 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 82 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | |
| IF UNDER 24 HRS. HOURS / MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland |
| 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Allegany MD. |
| 10. CITY OR TOWN OF DEATH | Frostburg |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Frostburg Community Hospital |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Miner |
| 12b. KIND OF BUSINESS OR INDUSTRY | Clay Mines |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland |
| 13b. COUNTY | Garrett |
| 13c. CITY OR TOWN | Frostburg |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | |
| 13e. STREET ADDRESS | Rt. 2. |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Albert Klink |
| 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Annie Livengood |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No |
| (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 220-46-8865 |
| 17. INFORMANT ADDRESS | Mr. David Klink, Frostburg, Md. 21532 Rt. 2, Box 474 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Failure | 7 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Respiratory Infection and Congestive heart Failure. | 30 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Urinary tract Infection. old age.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 1975 to 10.15 19 77, that (I) (we) last saw the deceased alive on 10.15 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| S Sandhir | M D | | 10/17/77 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | S. L. Sandhir, M.D. | 22e. ADDRESS | Fbg Comm. Hosp., Frostburg, Md. 21532 |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | Oct. 18, 1977 |
| 23c. NAME OF CEMETERY OR CREMATORY | Johnson Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Garrett County, Maryland |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | Durst Funeral Home, Frostburg, Md. 21532 | 25a. DATE REC'D BY REGISTRAR | OCT 24 1977 |
| 25b. REGISTRAR'S SIGNATURE | | | |

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

77 23225
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | |
|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | FLORENCE ESTELLA LARSON |
| 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 23, 1977 |
| 2b. HOUR | 5:30A M |
| 3. SEX | Female |
| 4. RACE | Caucasion |
| 5. DATE OF BIRTH MONTH DAY YEAR | August 18 1892 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 85 YRS. |
| IF UNDER 1 YEAR MONTHS DAYS | |
| IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Iowa |
| 7b. CITIZEN OF WHAT COUNTRY? | U S A |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | ALLEGANY COUNTY MD. |
| 10. CITY OR TOWN OF DEATH | Cumberland |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | SACRED HEART HOSPITAL |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY | Own Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md |
| 13b. COUNTY | Allegany |
| 13c. CITY OR TOWN | Cumberland |
| 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | |
| 13e. STREET ADDRESS | 12 Decatur St. |
| 14. FATHER'S NAME FIRST MIDDLE LAST | W. C. Rose |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | Lillian Bissell |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO |
| (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 214-46-2995 |
| 17. INFORMANT ADDRESS | Dr. E. W. Larson, as above |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis

1538

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Colon

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. **I certify** that (I) (this hospital) attended the deceased from June, 19 76, to Oct 23, 19 77, that (I) (we) last saw the deceased alive on ____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE W. C. Spiggle DEGREE ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAYNE C. SPIGGLE, M.D.

22e. ADDRESS 912 SETON DRIVE, CUMBERLAND, MD. 21502

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY STATE |
| Burial | Oct. 25, 1977 | Sunset Mem. Park | Allegany Co. | Md. |

24. FUNERAL DIRECTOR NAME ADDRESS: JOHN J. HAFER FUNERAL HOME, 302 NATIONAL HIGHWAY, LAVALE, MD.

25a. DATE REC'D. BY REGISTRAR: OCT 27 1977

25b. REGISTRAR'S SIGNATURE: Audrey McCready

BP____

DHMH - 1650M 1/76 (VR A 15 (4))

77 2222

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23226

1. DECEASED NAME (TYPE OR PRINT): FIRST Ruth; MIDDLE Janet; LAST Lashbaugh

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 10 DAY 15 YEAR 77 — 2b. HOUR 6a M

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH Oct. DAY 24, YEAR 1918 — 6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS. — IF UNDER 1 YR.: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 15 YEAR 77 — 2d. HOUR 6a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Frostburg — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frostburg Comm. Hosp. DOA — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife — 12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Frostburg — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 42 Frost Village

14. FATHER'S NAME: FIRST James; MIDDLE; LAST Walker

15. MOTHER'S MAIDEN NAME: FIRST Janet; MIDDLE; LAST Brimlow

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-12-3999

17. INFORMANT: Miss Deborah Lashbaugh, ADDRESS: Frostburg, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a): Coronary Occlusion

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden / "

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Benedict Skitarelic — M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 10-15-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic — ADDRESS: RD 9, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Oct. 18, 1977 — 23c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Pk. — 23d. LOCATION CITY OR TOWN, COUNTY, STATE: Frostburg, Allegany, Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Durst Funeral Home, Frostburg, Md.

25a. DATE REC'D BY REGISTRAR: OCT 20 1977 — 25b. REGISTRAR'S SIGNATURE:

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23227

1. DECEASED NAME (TYPE OR PRINT): First: Cleo; Middle: Belle; Last: Lee
2a. DATE OF DEATH: October 11, 1977
2b. HOUR: 1:05 P.M.
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH: June 8, 1911
6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Crellin, Md.
7b. CITIZEN OF WHAT COUNTRY?: U S A
8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Lions Manor Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Garrett
13c. CITY OR TOWN: Mt. Lake Park
13d. INSIDE CITY LIMITS? YES X NO ☐
13e. STREET ADDRESS: 701 "I" Street

14. FATHER'S NAME: First: Benjamin; Middle: Harrison; Last: DeWitt
15. MOTHER'S MAIDEN NAME: First: Ruth; Middle: Alberta; Last: Stahl
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 215-42-4700
17. INFORMANT'S NAME AND ADDRESS: Business Office, Lions Manor Nursing Hm. Seton Drive e xt., Cumberland, Md. 21502

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sepsis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours
402X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonitis — Hours
DUE TO, OR AS A CONSEQUENCE OF (c): CVA with Respiratory depression — 6 wks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES mellitus; Hypertension, Carcinoma breast

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO X
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-4, 19 77, to 10-11, 19 77, that (I) (we) last saw the deceased alive on 10-11 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Jane A. Fiscus, MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN X
22c. DATE SIGNED: 10/11/77
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jane A. Fiscus, M.D.
22e. ADDRESS: Lions Manor Nursing Home, Seton Dr. ext., Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial
23b. DATE: 10/14/77
23c. NAME OF CEMETERY OR CREMATORY: Garrett Co. Mem. Gards.
23d. LOCATION: CITY OR TOWN; COUNTY: Oakland; STATE: Garrett, Maryland
24. FUNERAL DIRECTOR: NAME: Bradley A. Stewart; ADDRESS: Oakland, Maryland 21550
25a. DATE REC'D. BY REGISTRAR: OCT 19 1977
25b. REGISTRAR'S SIGNATURE: Kathryn McCready

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 1660M 1/75
(VR A 15 (4))

77 23227

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23228

1. DECEASED NAME (TYPE OR PRINT): First James; Middle Roy; Last Lewis

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ Month Oct. Day 24, Year 19 77

2b. HOUR 11:55 A.M.

2c. DATE PRONOUNCED DEAD: Month Oct. Day 24, Year 19 77

2d. HOUR 11:55 A.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Month Oct. Day 15, Year 1921

6. AGE (IN YEARS) LAST BIRTHDAY: 56 YRS.

IF UNDER 1 YR. — MONTHS / DAYS

IF UNDER 24 HRS. — HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Allegany Infirmary

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Chauffeur

12b. KIND OF BUSINESS OR INDUSTRY: Taxi,

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland,

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS: 639 N. Mechanic St. (Formerly,)

14. FATHER'S NAME: First James; Middle Roy; Last Lewis

15. MOTHER'S MAIDEN NAME: First Carrie; Middle --; Last Mullen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No,

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-12-3369

17. INFORMANT ADDRESS: Allegany Infirmary Records,

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION,

Conditions, if ony, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN / ---- / ----

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection XX, Inquiry XX, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER

DATE SIGNED: Oct. 24, 1977

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M. D. ADDRESS: Rt. # 9 Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/27/77

23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Centerville, Bedford Penna.

24. FUNERAL DIRECTOR NAME: H. Wayne George ADDRESS: 202 Greene St. Cumberland, Md. 21502

25a. DATE REC'D. BY REGISTRAR: OCT 31 197

25b. REGISTRAR'S SIGNATURE: Audrey McCready

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23 23229

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: GEORGE | MIDDLE: CALVIN | LAST: LEYDIG | 2a. DATE OF DEATH MONTH: OCTOBER | DAY: 5th | YEAR: 1977 | 2b. HOUR: 11:05 MP |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH: April | DAY: 18 | YEAR: 1914 | 6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Trucker | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | | 13e. STREET ADDRESS: RD#1 Homewood Addition | |
| 14. FATHER'S NAME FIRST: Howard | MIDDLE: Leydig | LAST | 15. MOTHER'S MAIDEN NAME FIRST: Ida | MIDDLE: Mull | LAST: Leydig | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 217-07-2162 | 17. INFORMANT: Mrs. Dolly Leydig, Cumberland, Md, R | ADDRESS: RD#1 21502 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

575X IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial Infarction - Suspected

DUE TO, OR AS A CONSEQUENCE OF (c): Acute Coronary Stenosis — 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 10/4 19 77 to 10/5 19 77, that (I) (~~we~~) last saw the deceased alive on 10/5 19 77, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: Richard T Snider DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: Oct. 7, 77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): RICHARD SNIDER, M.D.

22e. ADDRESS: P.O. BOX 2455, CUMBERLAND, MD 21502

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Oct. 9, 1977 | 23c. NAME OF CEMETERY OR CREMATORY: Comps Cemetery | 23d. LOCATION CITY OR TOWN: Hyndman, PA. | COUNTY: RD Somerset Co. |
| 24. FUNERAL DIRECTOR NAME: ZEIGLER FUNEAL HOME | ADDRESS: HYNDMAN, PA 15545 | 25a. DATE REC'D. BY REGISTRAR: OCT 12 1977 | 25b. REGISTRAR'S SIGNATURE: Kathryn McCready | |

7 7 2 3

GEORGE CELVIN LEVOIG OCTOBER 4, 1977 11:05 P

ALLEGHNY COUNTY

SACRED HEART H SPITAL

RICHARD SNIDER, M.D. P.O. BOX 2455, CUMBERLAND, MD 21502

ZEIGLER FUNERAL HOME HARRISON, PA 15545

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23230

1. DECEASED NAME (TYPE OR PRINT): FIRST Lester MIDDLE M LAST Leydig
2a. DATE OF DEATH: MONTH DAY YEAR October 5, 1977
2b. HOUR 4:15 P M
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH DAY YEAR 05-02-90
6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ~~Pennsylvania~~ Bedford, Penna.
7b. CITIZEN OF WHAT COUNTRY? U S A
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Lions Manor Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): R. R. Telegraph Opr.
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Pennsylvania
13b. COUNTY
13c. CITY OR TOWN: Buffalo Mills
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: Rt. #1, Box 128

14. FATHER'S NAME: FIRST Benjamin MIDDLE LAST Leydig
15. MOTHER'S MAIDEN NAME: FIRST Martha MIDDLE LAST Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO. 705-03-7505
17. INFORMANT ADDRESS: Business Office-Lions Manor Nursing Hm. Seton Drive ext., Cumberland, Md. 21502

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
IMMEDIATE CAUSE (a) H123 Pulmonary Embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure — months
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): UTI ; Ca. of BPH & prostate

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-16, 19 77, to 10-5, 19 77, that (I) (we) last saw the deceased alive on 10-5-77, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Jane A. Fiscus, MD
DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED 10/6/77
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jane A. Fiscus, M.D.
22e. ADDRESS: Lions Manor Nursing Home Seton Drive ext., Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct. 8, 1977
23c. NAME OF CEMETERY OR CREMATORY: Lybarger Cemetery
23d. LOCATION CITY OR TOWN: Buffalo Mills, Pa. STATE: RD#1 Bedford County
24. FUNERAL DIRECTOR NAME ADDRESS: Harvey H. Zeigler, Hyndman, Pa. 15545
25a. DATE REC'D. BY REGISTRAR: OCT 14 1977
25b. REGISTRAR'S SIGNATURE: Victory McCready

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 1660M 1/75
(VR A 15 (4))

77 23230

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23231

1. DECEASED NAME (TYPE OR PRINT) — FIRST: HERBERT — MIDDLE: ELLSWORTH — LAST: LOAR

2a. DATE OF DEATH — MONTH DAY YEAR: OCTOBER 12, 1977

2b. HOUR: 11:58PM

3. SEX: Male

4. RACE: Caucasion

5. DATE OF BIRTH — MONTH DAY YEAR: March 29, 1904

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS, HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Merchant

12b. KIND OF BUSINESS OR INDUSTRY: Grocery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Frosyburg

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 117 Frost Avenue

14. FATHER'S NAME — FIRST: Elijah — MIDDLE — LAST: Loar

15. MOTHER'S MAIDEN NAME — FIRST: Retta — MIDDLE — LAST: Boor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 216-14-1883

17. INFORMANT: Neva Loar — ADDRESS: Same as above

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

4.109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): A-S-C.V.D., Mitral Insufficiency.

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C.J. Vincent M.D. — DEGREE — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. CLARENCE VINCENT

22e. ADDRESS: 909 B-SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/15/77

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

23d. LOCATION — CITY OR TOWN: Frostburg — COUNTY: Allegany — STATE: Md.

24. FUNERAL DIRECTOR — NAME AND ADDRESS: HAFER FUNERAL HOME, FROSTBURG, MD. 21532

25a. DATE REC'D. BY REGISTRAR: OCT 20 1977

25b. REGISTRAR'S SIGNATURE: Courtney McCreary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23232

1. DECEASED NAME (TYPE OR PRINT): George W. Long

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — MONTH 10 DAY 22 YEAR 1977

2b. HOUR 11:05 PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 8 DAY 17 YEAR 1899

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 22 YEAR 1977

2d. HOUR 11:05 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hosp. (DOA)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret.

12b. KIND OF BUSINESS OR INDUSTRY: B & O RR

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: WV

13b. COUNTY: Mineral

13c. CITY OR TOWN: Ridgeley

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Rt. 2, Box 217

14. FATHER'S NAME: Phillip Long

15. MOTHER'S MAIDEN NAME: Mary Catherine Westbroke

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-05-9272

17. INFORMANT ADDRESS: Mrs. George W. Long Ridgeley, WV

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis — ----

DUE TO, OR AS A CONSEQUENCE OF

(c)

4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 10-22-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic ADDRESS: Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10-26-1977

23c. NAME OF CEMETERY OR CREMATORY: Betson-Culp Cemetery

23d. LOCATION CITY OR TOWN: Near Ridgeley COUNTY: W. Va. STATE

24. FUNERAL DIRECTOR: Scarpelli, ADDRESS: Cumberland, Maryland

25a. DATE REC'D. BY REGISTRAR: OCT 28 1977

25b. REGISTRAR'S SIGNATURE: Kirkpatrick McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR RECORDS.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 77 23233

1 - FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): FIRST HARVEY; MIDDLE GILLUM; LAST LOWERY
2a. DATE OF DEATH: MONTH OCTOBER DAY 15 YEAR 1977
2b. HOUR: 1:50A M
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH Feb. DAY 23, YEAR 1898
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Celanese ret.
12b. KIND OF BUSINESS OR INDUSTRY: Textiles

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Penna.
13b. COUNTY: Bedford
13c. CITY OR TOWN: Hyndman
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: RD#1 Londonderry Twshp.

14. FATHER'S NAME: FIRST Noah; MIDDLE; LAST Lowery
15. MOTHER'S MAIDEN NAME: FIRST Annie; MIDDLE Clites; LAST Lowery
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 217-10-6237
17. INFORMANT ADDRESS: Mrs. Pearl B. Lowery, Hyndman, RD#1 15545

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO, OR AS A CONSEQUENCE OF (b): ASHD — 10 years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George Breza DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED: 10/15/77
22d. PHYSICIAN'S NAME (TYPE OR PRINT): George Breza
22e. ADDRESS: 912 Seton Drive, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct. 18, 1977
23c. NAME OF CEMETERY OR CREMATORY: Porter CEmetery
23d. LOCATION CITY OR TOWN: Hyndman, COUNTY: Bedford, STATE: Penna. RD#1 15545

24. FUNERAL DIRECTOR NAME: ZIEGLER'S FUNEAL HOME ADDRESS: HYNDMAN, PA. 15545
25a. DATE REC'D. BY REGISTRAR: OCT 20 1977
25b. REGISTRAR'S SIGNATURE: Kathryn McCready

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 36 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 1/75
(VR A 15 (4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
# DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 77 23234

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MICHAEL | MIDDLE: J. | LAST: MATTINGLY | 2a. DATE OF DEATH MONTH DAY YEAR: OCTOBER 25, 1977 | 2b. HOUR: 1935P | M |
| 3. SEX: m | 4. RACE: w | 5. DATE OF BIRTH MONTH DAY YEAR: May 9 1897 | 6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: US of A | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. | 12b. KIND OF BUSINESS OR INDUSTRY: Brewing Co. | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Allegany | Cumberland | YES [X] NO [ ] | 219 Springdale Street |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| James T. Mattingly | Rosalia Topper |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WW I | 214-05-4767 | Dora S. Mattingly Cumberland, MD |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma, stomach with metastasis

1519

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct, 1977, to 25 Oct, 1977, that (I) (~~we~~) last saw the deceased alive on 25 Oct, 1977, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Carlton Brinsfield MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 10-28-77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. CARLTON BRINSFIELD | 401 DECATUR ST, CUMBERLAND MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10-28-77 | Forest Glen Cemetery | Cumberland Allegany MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE RECD. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| James F. Scarpelli | Cumberland, MD | OCT 31 1977 | Mary McCready |

77 23234

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

77 23235
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/76
(VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT) — FIRST: CLEMENT — MIDDLE: COLUMBUS — LAST: MAY
2a. DATE OF DEATH — MONTH DAY YEAR: OCTOBER 13, 1977
2b. HOUR: 2:25AM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: Apr. 24, 1904
6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired
12b. KIND OF BUSINESS OR INDUSTRY: Ballistic Co

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 12006 Mc Mullen Highway

14. FATHER'S NAME — FIRST MIDDLE LAST: Aaron May
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Mary Straub
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: Mrs.Mary M. May, Cumberland, Md. Wife

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
4109
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — yrs
DUE TO, OR AS A CONSEQUENCE OF (c): Atheromatosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Heart Block - Phlebitis

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: V Mazzocco — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10-18-77
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. V. MAZZOCCO
22e. ADDRESS: SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10-15-1977
23c. NAME OF CEMETERY OR CREMATORY: SS.Peter & Paul Cem.
23d. LOCATION — CITY OR TOWN COUNTY STATE: Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR — NAME ADDRESS: SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMBERLAND MD. 21502
25a. DATE REC'D. BY REGISTRAR: OCT 19 1977
25b. REGISTRAR'S SIGNATURE: Kirtsy McCready

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23236

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b HOUR | |
| MARIE | JANE | MCKENZIE | OCTOBER 8, 1977 | 11:20 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
| FEMALE | WHITE | 10 - 7 - 19 | 58 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| SALISBURY, PA | USA | | ALLEGANY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CUMBERLAND | SACRED HEART HOSPITAL | HOUSEWIFE | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| PA. | SOMERSET | SALISBURY | YES ☐ NO ☒ | R.D #1 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15 MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| WILLIAM | | BROWN | LELA | J. | HARDING |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (DAUGHTER) NAME | ADDRESS |
|---|---|---|---|---|
| NO | | 212-24-0138 | NAOMI KNOPSNYDER | RD #1 - SALISBURY, PA 15558 |

**MEDICAL CERTIFICATION**

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(a) IMMEDIATE CAUSE: Metastatic Ca of the liver - failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Ca of breast

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. **I certify** that (I) (this hospital) attended the deceased from 10-2-77, 19__, to 10-9, 19 77, that (I) (we) last saw the deceased alive on 10-9, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10-10-77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. J. MEHANNA | 909 SETON DR., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR ~~CREMATORY~~ | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 10-11-77 | SALISBURY CEMETERY | SALISBURY - SOMERSET - PA. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| THOMAS FUNERAL HOME, SALISBURY, PA. 15558 | OCT 14 1977 | [signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/76 (VR A 15 (4))

77 2323 6

MARIE JANE MCKENZIE OCTOBER 3, 1977 11:20A

ALLEGANY COUNTY

SACRED HEART HOSPITAL

DR. J. MEHAMA 900 SETON DR., CUMBERLAND, MD.

THOMAS FUNERAL HOME, SALISBURY, MD. 1555

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

77 23237
REG. NO.

M

1. DECEASED NAME (TYPE OR PRINT): Effie R. Miller
2a. DATE OF DEATH: October 2, 1977
2b. HOUR:
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Oct. 4, 1889
6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: Lonaconing
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kyle Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Frostburg
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 75 Frost Village

14. FATHER'S NAME: Alfred E. Reppert
15. MOTHER'S MAIDEN NAME: Virginia Hair
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 261-43-7045
17. INFORMANT ADDRESS: Mr. James H. Evans, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized ASCVD — years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
412.4

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from ____ 19 75 to Oct 2 19 77, that (I) (we) last saw the deceased alive on Sept. 30 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10-3-77
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Leslie R. Miles, M.D.
22e. ADDRESS: State St., Lonaconing, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct.4,1977
23c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park
23d. LOCATION CITY OR TOWN: Frostburg COUNTY: Alleg. STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Durst Funeral Home, Frostburg, Md. 21532
25a. DATE REC'D. BY REGISTRAR: OCT 6 1977
25b. REGISTRAR'S SIGNATURE: [signature]

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23238

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ESTIMATED ☒ MONTH | DAY | YEAR | 2b. HOUR |
| GILBERT | OTTO | MILLER | OCT. | 25, | 77 | 1:00 P M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| MALE | WHITE | AUG. 7, 1913 | 64 YRS. | | | Oct. 25, 1977 | 3:00 P M |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| MARYLAND | U.S.A. | | ALLEGANY MD. |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| FROSTBURG | GUNTER HOTEL, W. MAIN ST. | DISPATCHER | TAXI |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| MARYLAND | ALLEGANY | FROSTBURG | YES ☒ NO ☐ | GUNTER HOTEL, W. MAIN ST. |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
| EDWARD | MILLER | VERNA | J. THOMAS |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| NO | N.A. | 214-12-3151 | MR. GILBERT E. MILLER, HAGERSTOWN, MD. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (b) | CORONARY SCLEROSIS | --- |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | | |

4109
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |

| | | |
|---|---|---|
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER DATE SIGNED 10/25/77

EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D. ADDRESS BALTIMORE PIKE, CUMBERLAND, MD.

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
| BURIAL | 10/27/77 | ECKHART CEMETERY | ECKHART | ALLEGANY | MD. |

| | | | |
|---|---|---|---|
| 24. FUNERAL DIRECTOR NAME / ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Marilyn M. Sowers SOWERS FUNERAL HOME | FROSTBURG, 60 W. MAIN ST. | NOV 1 1977 | Kathryn McCready |

BP____

DHMH - 17
(VR A15 ME (5))
30M 7/73

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

77 23239
REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES | MIDDLE: TIBBETT MILLER | LAST: MILLER | 2a. DATE OF DEATH MONTH DAY YEAR: 10-20-77 | | 2b. HOUR: 12:20PM M |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: August 11, 1893 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9 BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY CO., MD. | | MD. |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pipe Fitter | | 12b. KIND OF BUSINESS OR INDUSTRY: Textile Corp. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | LaVale | YES ☒ NO ☐ | 7 Richard Way |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | |
|---|---|---|
| Charles O. Miller | Bridget C. Naughton | ADDRESS LaVale, Maryland |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17 INFORMANT |
|---|---|---|---|
| No, | | 214-07-0557 | Mrs. Helen C. Furstenberg, 7 Richard Way |

## MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Cardio - Pulmonary Arrest

4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardio-Vascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Chronic Obstructive Pulmonary Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Emphysematic Psychosis associated w Cerebral Arteriosclerosis, Diabetes Mellitus, Hypertension

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| X | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| X | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Edward M. Lipski | MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 10/20/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| EDWARD M. LIPSKI, M.D.<br>ANTHONY DE MUNECAS M.D. | 201 WASHINGTON ST., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Oct. 24, 1977 | SS. Peter & Paul Cath. Cem. | Cumberland, Allegany, Md. |

| 24 FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| XXXX GEORGE FUNERAL HOME | 202 GREENE ST., CUMBERLAND, MD. | OCT 27 1977 | |

CHARGE $15.00

77 2329

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 77 23240

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | SCHRILLA | MIDDLE BERNADEAN | LAST MILLER |
| 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 15, 1977 | | 2b. HOUR 11:25 PM |
| 3. SEX | FEMALE | | |
| 4. RACE | White. | | |
| 5. DATE OF BIRTH MONTH DAY YEAR | Jan. 7, 1921 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 56. YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA. | | |
| 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | ALLEGANY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | Cumberland | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | SACRED HEART HOSPITAL | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE) | H/W. | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | — | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md. | 13b. COUNTY Garret | 13c. CITY OR TOWN Grantsville |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | | | |
| 13e. STREET ADDRESS | Rt. 2 | | |
| 14. FATHER'S NAME FIRST | IRA. | MIDDLE NMI. | LAST Glotfelty. |
| 15. MOTHER'S MAIDEN NAME FIRST | Florence | MIDDLE | LAST Niner. |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No. | (IF YES, GIVE WAR OR DATES) --- | |
| 16b. SOCIAL SECURITY NO. | 215-34-4808 | | |
| 17. INFORMANT | W.E.Miller, | ADDRESS Grantsville, Md. 21536 | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.

DUE TO, OR AS A CONSEQUENCE OF (b) Ca. Right Breast. — 1 yr.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | — |
| 20a. AUTOPSY? YES ☐ NO ☒ | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 14 Oct 19 77 to 15 Oct 19 77, that (I) (we) last saw the deceased alive on ____ 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Wm. L. Bartlett, M.D. for ANDREW STASKO M.D. — DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED 19 Oct 77

22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW STASKO M.D. — 22e. ADDRESS 924 SETON DRIVE, CUMBERLAND, MD 21502

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE 10-18-77 | 23c. NAME OF CEMETERY OR CREMATORY Grantsville Cem. |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | Grantsville, Garrett, Md. | | |
| 24. FUNERAL DIRECTOR NAME | D. L. Newman | ADDRESS | |
| NEWMAN'S FUNERAL HOME | GRANTSVILLEM MD. | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| | | OCT 24 1977 | Kathryn McClung |

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))

77 2 3 2 4 0

SCHRILLA BENJAMIN MILLER OCTOBER 15, 1977 11:25 P

ALLEGANY COUNTY

SACRED HEART HOSPITAL

ANDREW STASKO M.D. 924 SETON DRIVE, CUMBERLAND, MD 21502

BENNETT'S FUNERAL HOME GM TSVILLEX MD.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR — REG. NO. 77 23241

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE F. LAST Miller

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH Oct. DAY 23, YEAR 77 — 2b. HOUR 10:05 A M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH Aug. DAY 11, YEAR 1915 — 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Oct. DAY 23, YEAR 1977 — 2d. HOUR 10:05 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md. — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital - ROA. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Superintendent — 12b. KIND OF BUSINESS OR INDUSTRY: City Waste Treatment

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Cumberland — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 523 Valley St.

14. FATHER'S NAME: FIRST James MIDDLE W. LAST Miller

15. MOTHER'S MAIDEN NAME: FIRST Bessie MIDDLE LAST Valentine

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 214-07-5717

17. INFORMANT — ADDRESS: Freda B. Miller Cumberland, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
4109
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b): CORONARY SCLEROSIS — ****
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE Benedict Skitarelic M.D. — TITLE (SPECIFY): DEPUTY MEDICAL EXAMINER — DATE SIGNED Oct. 23, 1977

EXAMINER'S NAME (TYPE OR PRINT): BENEDICT SKITARLIC, M.D. — ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Oct 25, 1977 — 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial P. — 23d. LOCATION CITY OR TOWN: Cumberland — COUNTY: Allegany — STATE: Md.

24. FUNERAL DIRECTOR NAME: Kight — ADDRESS: Cumberland, Maryland

25a. DATE REC'D. BY REGISTRAR: OCT 28 1977 — 25b. REGISTRAR'S SIGNATURE: Kirkpatrick McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS. AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23242

1. DECEASED NAME (TYPE OR PRINT): First Vincent; Middle DePaul; Last Miltenberger

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month 10 Day 5 Year 77 — 2b. HOUR 4:55 P.M.

3. SEX: Male — 4. RACE: ~~Race~~ White — 5. DATE OF BIRTH: Month Aug. Day 15, Year 1907 — 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month 10 Day 5 Year 77 — 2d. HOUR 4:55 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va. — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital---DOA — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Meat Cutter — 12b. KIND OF BUSINESS OR INDUSTRY: Butcher Shop

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: LaVale — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 20 C. St.

14. FATHER'S NAME: First George; Middle D.; Last Miltenberger

15. MOTHER'S MAIDEN NAME: First Mary; Middle E.; Last Wolfe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No, — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Margaret E. Miltenberger — ADDRESS: LaVale, Md. 20 C. St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

Conditions, if ony, which gave rise to immediate cause (a) stating the underlying cause last.

(a) IMMEDIATE CAUSE: Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

(b) DUE TO, OR AS A CONSEQUENCE OF: Coronary Sclerosis — ---

(c) DUE TO, OR AS A CONSEQUENCE OF:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Benedict Skitarelic M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 10-5-77

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. — ADDRESS R#9, Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 10/8/77 — 23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem. — 23d. LOCATION CITY OR TOWN: Cumberland, COUNTY: Allegany, STATE: Maryland

24. FUNERAL DIRECTOR NAME: H. Wayne George — ADDRESS: 202 Greene St. Cumberland, Maryland 21502 — 25a. DATE REC'D. BY REGISTRAR: OCT 10 1977 — 25b. REGISTRAR'S SIGNATURE: Tiffany McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 77 23243

1. DECEASED NAME (TYPE OR PRINT) — FIRST: LESTER; MIDDLE: W.; LAST: MORRIS

2a. DATE OF DEATH — MONTH DAY YEAR: OCT. 28, 1977

2b. HOUR: 11:15A M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: June 19, 1906

6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: B and O RR

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 629 Leiper St.

14. FATHER'S NAME — FIRST: UNK.; MIDDLE; LAST

15. MOTHER'S MAIDEN NAME — FIRST: Queen; MIDDLE: Elizabeth; LAST: Morris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220 10 2027

17. INFORMANT: Jack A. Pifer ADDRESS: 117 Columbia St. Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebro Vascular Accident, Cerebral H'ge

DUE TO, OR AS A CONSEQUENCE OF (b): Advanced Cerbal Arteriosclerosis.

DUE TO, OR AS A CONSEQUENCE OF (c):

#339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cardiac Cachexia.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: M. A. Ranjithan DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 11/2/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. NAGARATNAM RANJITHAN

22e. ADDRESS: MEMORIAL HOSPITAL MEDICAL BUILDING, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 30 Oct 77

23c. NAME OF CEMETERY OR CREMATORY: Meadow Point

23d. LOCATION — CITY OR TOWN: Keyser; COUNTY: Mineral; STATE: W. Va.

24. FUNERAL DIRECTOR — NAME: Allen M. Rotruck ADDRESS: Keyser, W. Va.

25a. DATE RECD. BY REGISTRAR: NOV 7 1977

25b. REGISTRAR'S SIGNATURE:

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 77 23244

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: LLOYD | MIDDLE: E | LAST: MULLIN | 2a. DATE OF DEATH MONTH DAY YEAR: OCTOBER 26, 1977 |
| | | | 2b. HOUR: 10:10 M |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: 3 18 1882 | 6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS. |
| | | | IF UNDER 1 YEAR: MONTHS DAYS |
| | | | IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNA | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RET, SALESMAN |
| | | | 12b. KIND OF BUSINESS OR INDUSTRY: PAPER, CO |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 423 BEALL ST. CUMB, MD. |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JAMES | A. | MULLIN | MARY | | RUPPERT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | | 214-09-1624 | MAUDIE A. TASHENBERGER. OLDTOWN, MD. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 mts

DUE TO, OR AS A CONSEQUENCE OF (b): [illegible]

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 10/13/77, 19__, to 10/26/77, 19__, that (I) (we) last saw the deceased alive on 10/26/77, 19__, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 10/27/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. W. GUY FISCUS | MEMORIAL MEDICAL BLDG, CUMBERLAND, MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| ENTOMBMENT | 10-29-1977 | ROSE HILL MAUSOLEUM | CUMBERLAND ALLEGANY MARYLAN |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| LEASURE-STEIN FUNERAL HOME. | 830 Baltimore ave CUMBERLAND, MD. | OCT 31 1977 | [signature] |

BP

DHMH - 1660M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23245

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| JESSIE | P. | NAILL | OCTOBER 30-1977 | 2255P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | Feb 27 1894 | 83 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | U.S.A. | | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Housekeeper------ | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES ☒ NO ☐ | 608 Ann's Place |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Thomas | Henry | Leasure | Anna | Belle | Barnes |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 214-52-1805 | Mrs. Leona Pyles | Box 31 Corriganville, Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Atherosclerotic heart disease c acute left ventricular failure

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c) Pancreatitis c acute, subsidy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Atherosclerotic heart disease c secondary myocardial infarction

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 77, to 10/30, 19 77, that (I) (we) last saw the deceased alive on 10/30/77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| S.G. Weisman | MD | | 11/1/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. S.G.WEISMAN | 59 GREENE ST, CUMBERLAND MD |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Nov 2,1977 | Fairview Christian Cem | Inglesmith Bedford Penna |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Silcox-Merritt Funeral Service. | 404 Decatur St Cumberland, Md | NOV 3 1977 | Kathryn McCready |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1660M 1/75
(VR A 15 (4))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 1/75
(VR A 15 (4))

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 77 23246

1. DECEASED NAME (TYPE OR PRINT): FIRST DAVID MIDDLE D. LAST NORRIS
2a. DATE OF DEATH: MONTH OCTOBER DAY 23 YEAR 1977
2b. HOUR: 5:00 AM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH Jan DAY 19 YEAR 1889
6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Owner
12b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Flintstone
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS:

14. FATHER'S NAME: FIRST Andrew MIDDLE LAST Norris
15. MOTHER'S MAIDEN NAME: FIRST Florence MIDDLE LAST Stottlemyer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 214-32-3126
17. INFORMANT: Mrs. Margaret Norris ADDRESS: Flintstone, Md

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Intestinal Obstruction
DUE TO, OR AS A CONSEQUENCE OF (c): Marked CVA's - multiple; CAD; CHF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct. 13 19 77 to Oct. 23 19 77, that (I) (we) last saw the deceased alive on Oct. 22 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD
ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 10-24-77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. TERRY E. WILLIAMS
22e. ADDRESS: MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct 25, 1977
23c. NAME OF CEMETERY OR CREMATORY: Piney Plains Cemetery
23d. LOCATION CITY OR TOWN COUNTY STATE: Flintstone Allegany Maryland

24. FUNERAL DIRECTOR NAME: Silcox-Merritt Funeral Service. ADDRESS: 404 Decatur St Cumberland, Md
25a. DATE REC'D. BY REGISTRAR: OCT 28 1977
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23247

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| EMMA | ELIZABETH | NORRIS | OCTOBER 31, 1977 | 6:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | March 28, 1929 | 48 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| W. Va. | USA | | ALLEGANY COUNTY MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | SACRED HEART HOSPITAL | Housewife | Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS |
|---|---|---|---|---|
| W. Va. | Mineral | Keyser | | Rt. 1, Box 72-H Limestone Rd., Keyser, W.Va |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Albert | -- | Kashmier | Anna | | Capusta |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | None | 233-44-2138 | Carl Norris, Limestone Rd., Keyser, |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Multiple metastasis | 2 months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | carcinoma (R) lung | 3 " |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

1621

Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify thot (I) (this hospitol) ottended the deceosed from 10/20/, 1977, to 10/31/, 1977, thot (I) (we) lost sow the deceosed olive on 10/31/, 1977, ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| A. Sivan Pillai | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] | 11/1/1977 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| A. SIVAN PILLAI, M.D. | 915 SETON DRIVE, CUMBERLAND, MD 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Nov. 3, 1977 | Potomac Mem. Gardens, | Keyser, Mineral, W.Va. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MARKWOOD FUNERAL HOME | 11 MINERAL STREET KEYSER. W. VA. 26726 | NOV 3 1977 | Whitney McCready |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/76
(VR A 15 (4))

77 2322

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23248

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR | 2b. HOUR |
| Janice | LEE | Northcraft | 10-8-77 19 | 6p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | 9-8-29 | 48 YRS. | | | | | 10-8-77 19 | 6p M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Housewife | Own Home |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES [X] NO [ ] | 22 North Waverly Terrace |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| John Lookabaugh | Copaline Wiseman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 214 28 7087 | W. Earl Northcraft, as above |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary Insufficiency | Months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Sclerosis | ---- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4123

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Edema, Hydrothorax; bilateral

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [XX], Inquiry [XX], and in my opinion death resulted from: Natural causes [XXX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 10-8-77

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS R#9, Cumberland, Maryland 21502

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 10/11/77 | Sunset Mem. Gardens | Allegany Co. Md. |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| John J. Hafer, Jr. LaVale, Maryland | OCT 13 1977 | Jeffrey McCready |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH · 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23249

1. DECEASED NAME (TYPE OR PRINT): FIRST Rose; MIDDLE P; LAST Parker

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 10 DAY 5 YEAR 77 — 2b. HOUR 5:50 PM

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH 10 DAY 26 YEAR 99 — 6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 5 YEAR 77 — 2d. HOUR 5:50 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: (Alllegany) Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife — 12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Marylan d — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Cumberland — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: R#5

14. FATHER'S NAME: FIRST George MIDDLE LAST Slezak

15. MOTHER'S MAIDEN NAME: FIRST Lena MIDDLE LAST Setz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 176-12-1915

17. INFORMANT ADDRESS: Mr. Alton B. Parker, Husband

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a): Maceration of Brain — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11 days

DUE TO, OR AS A CONSEQUENCE OF (b): Contusions of Brain — "

DUE TO, OR AS A CONSEQUENCE OF (c): (Pedestrian struck by vehicle) — "

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION: 9-23-77 — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Left Temporal Decompression — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 5:30 P.M. 9-21-77 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Pedestrian Struck by Vehicle

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Rt#40 East Slope

21f. LOCATION STREET: of Sideling Mt. CITY OR TOWN: COUNTY: Allegany STATE: Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 10-5-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M.D. — ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 10-8-1977 — 23c. NAME OF CEMETERY OR CREMATORY: Sylvania Cemetery — 23d. LOCATION CITY OR TOWN: Rochester, Beaver, COUNTY: Pa. STATE:

24. FUNERAL DIRECTOR NAME ADDRESS: James F. Scarpelli, Cumberland, Md. — 25a. DATE REC'D. BY REGISTRAR: OCT 13 1977 — 25b. REGISTRAR'S SIGNATURE: Audrey McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201**

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

#16b,FilmG514 12/5/77 kam

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 77 23250

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Blanche — MIDDLE: O. — LAST: Price

2a. DATE OF DEATH — MONTH: 10 — DAY: 27 — YEAR: 77

2b. HOUR: 10 46 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: June — DAY: 22, — YEAR: 1875

6. AGE (IN YEARS LAST BIRTHDAY): 102 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Cumberland Nursing Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Frostburg — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 39 W. Main St.

14. FATHER'S NAME — FIRST: Joseph — MIDDLE: B. — LAST: Oder

15. MOTHER'S MAIDEN NAME — FIRST: Margaret — MIDDLE: E. — LAST: Churchill

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220-44-1444

17. INFORMANT — ADDRESS: Mrs. Nancy Roe, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca Breast.
1744
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Marrow dysfunction.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/4, 19 77, to 10/27, 19 77, that (I) (we) last saw the deceased alive on 10/26, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 11/28/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): P.B. HALMOS

22e. ADDRESS: 300 Schlegel Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Oct. 31, 1977

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem Pk.

23d. LOCATION — CITY OR TOWN: Frostburg — COUNTY: Allegany — STATE: Md

24. FUNERAL DIRECTOR — NAME AND ADDRESS: Durst Funeral Home, Frostburg, Md. 21532

25a. DATE REC'D. BY REGISTRAR: NOV 3 1977

25b. REGISTRAR'S SIGNATURE: [signature]

BP_____

DHMH - 1660M 1/75
(VR A 15 (4))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 1/75
(VR A 15 (4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23251

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| EDGAR | | PUFFENBERGER | OCT. 9, 1977 | 7:45A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | July 5, 1915 | 62 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| West Virginia | USA | | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ME CUMBERLAND | MEMORIAL HOSPITAL | Retired Carman | Railroad |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES ☒ NO ☐ | Route 4, Oldtown Rd. |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| Albert Puffenberger | Carrie Johnston |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | | Mrs. Gelia Puffenberger, Cumberland, Wife |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiopulmonary arrest 20

DUE TO, OR AS A CONSEQUENCE OF (b) CAD + COPD chronic

DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary emboli

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 9-25 77, 19__, to 10-9 77, 19__, that (I) (we) last saw the deceased alive on 10-8 77, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| [signature] | MD | | 10-9-77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. TERRY WILLIAMS | MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 10-11-1977 | Mt. Tabor Cemetery | Cumberland, Allegany Md. |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | OCT 13 1977 | [signature] |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23252

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | LOUIS J. RIZER | 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 13, 1977 | 2b. HOUR | 1:05PM |
| 3. SEX | Male | 4. RACE | White | 5. DATE OF BIRTH MONTH DAY YEAR | Nov. 2, 1924 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 52 YRS | IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | West Virginia | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Allegany MD. | | | | |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Cook |
| 12b. KIND OF BUSINESS OR INDUSTRY | Ramada Inn | | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| W. Va. | Mineral | Wiley Ford | YES ☐ NO ☒ | none |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Louis J. Rizer | Bessie Shipley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | IF YES, GIVE WAR OR DATES | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | War II | | Brother | Mr. Roy A. Rizer, Fort Ashby, W. Va. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic CHF

425X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 10/6 19 77 to 10/12 19 77, that (I) (we) last saw the deceased alive on 10/12/77 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 10/14/77

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DR. THADDEUS H. ELDER | MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 10-16-1977 | Fort Ashby Cemetery | Fort Ashby, W. Va. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | OCT 19 1977 | Pinkney McCready |

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

77 23253
REG. NO.

1 - FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOSEPHINE MIDDLE: A. LAST: SCARCELLI

2a. DATE OF DEATH MONTH DAY YEAR: OCT. 27, 1977

2b. HOUR: 1:00P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: 9 22 1912

6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS

IF UNDER 1 YEAR MONTHS DAYS: IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: CUMBERLAND,

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Allegany

13c. CITY OR TOWN: Westernport

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 410 Maryland Avenue

14. FATHER'S NAME FIRST MIDDLE LAST: Felice Scalli

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Carmella Alvaro

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220-07-6043

17. INFORMANT: Phillip Scarcelli ADDRESS: Westernport, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiogenic Shock

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/26, 1977, to 10/27, 1977, that (I) (we) last saw the deceased alive on 10/27, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P.B. Halmos DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1/28/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. PETER HALMOS

22e. ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/31/77

23c. NAME OF CEMETERY OR CREMATORY: St. Peter's

23d. LOCATION CITY OR TOWN: Westernport COUNTY: Allegany STATE: Md.

24. FUNERAL DIRECTOR NAME: William A. Fredlock III ADDRESS: 31 Jones St. Piedmont, W. Va.

25a. DATE REC'D. BY REGISTRAR: NOV 7 1977

25b. REGISTRAR'S SIGNATURE: Kathryn McCready

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1660M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23254

1. DECEASED NAME (TYPE OR PRINT): FIRST Pamela MIDDLE Ann LAST Shipley

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 10 DAY 9 YEAR 77 — 2b. HOUR 11a

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH 07 DAY 27 YEAR 60 — 6. AGE (IN YEARS LAST BIRTHDAY): 17 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 9 YEAR 77 — 2d. HOUR 11a

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital --DOA — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cashier, — 12b. KIND OF BUSINESS OR INDUSTRY: Restaurant,

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: W.Va. — 13b. COUNTY: Mineral — 13c. CITY OR TOWN: Ridgeley — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: R#2 Old Furnace Rd.

14. FATHER'S NAME: FIRST James MIDDLE A. LAST Shipley

15. MOTHER'S MAIDEN NAME: FIRST Betty MIDDLE M. LAST Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No, — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 232-98-3310

17. INFORMANT ADDRESS: Mr. James A. Shipley, Rt. # 2 Ridgeley, 26753 W. Va.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a): Asphyxiation
DUE TO, OR AS A CONSEQUENCE OF
(b): Drowning
DUE TO, OR AS A CONSEQUENCE OF
(c): (Accidental)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes / #

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS: UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY: HOUR A.M. 10:25 MONTH 10 DAY 9 YEAR 77 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2): Driver and single occupant of auto which went into a pond.

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Rt. #28 4 mile South of Ridgeley — 21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE: Mineral, W.Va.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 10-9-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M.D. — ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 10/12/77 — 23c. NAME OF CEMETERY OR CREMATORY: Abe Cemetery, — 23d. LOCATION CITY OR TOWN, COUNTY, STATE: Nr. Ridgeley, Mineral W. Va.

24. FUNERAL DIRECTOR NAME: H. Wayne George — ADDRESS: 202 Greene St. — George, Cumberland, Maryland 21502

25a. DATE REC'D. BY REGISTRAR: OCT 14 1977 — 25b. REGISTRAR'S SIGNATURE: Tiffany McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR RECORDS.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201**

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 1/76
(VR A 15 (4))

1 - FOR STATE REGISTRAR

**STATE OF MARYLAND**
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**CERTIFICATE OF DEATH**

REG. NO. 77 23255

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Ethel [redacted] MIDDLE: ELLA LAST: SHIRER | | | | 2a. DATE OF DEATH MONTH DAY YEAR: OCTOBER 27, 1977 | 2b. HOUR: 7:40 AM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Aug 5 1900 | 6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY, MD. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pa | 13b. COUNTY: Fayette | 13c. CITY OR TOWN: Markleysburg | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: R D 1 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST: Marcellus Shantzer | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Millie Enlow | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 197-42-9340 | 17. INFORMANT: Harold Shirer | ADDRESS: Weirton W. Va. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Sepsis | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Multiple Myeloma | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Hypoglycemia & Hyperkalemia | |

203 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 10-5, 19 77, to 10-27, 19 77, that (I) (we) last saw the deceased alive on 10-27 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John Mehanna | DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 10-27-77 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN MEHANNA, M. D. | 22e. ADDRESS: 909B SETON DRIVE, CUMBERLAND, MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Oct 30 1977 | 23c. NAME OF CEMETERY OR CREMATORY: Sandom Chapel | 23d. LOCATION CITY OR TOWN: Henry Clay Twp COUNTY: Fayette STATE: Pa. | |
| 24. FUNERAL DIRECTOR NAME: Dan J Newman ADDRESS: Grantsville Md | | 25a. DATE REC'D. BY REGISTRAR: NOV 8 1977 | 25b. REGISTRAR'S SIGNATURE: Kathryn McCready | |

[redacted]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

77 23256
REG. NO.

1 - FOR STATE REGISTRAR

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Margaret | Davis | Smith | October 21, 1977 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | March 2, 1910 | 67 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| West Virginia | U.S.A. | | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Cumberland Memorial Hospital | Postmistress | Postal Serv. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| W. Va. | Hampshire | Junction | YES ☐ NO ☒ | General Delivery |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Fred | | Davis | Myrtle | | Bennett |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 234-38-8969 | Mrs. M. T. Maphis | Romney, W. Va. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pulmonary arrest | unknown |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Metastic Cancer of Breast | 16 Months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

1744
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Richard A. Bender MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Oct. 24, 1977 | Queens Point | Keyser Mineral W. Va. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Larry S. Miller | Romney, W. Va. | NOV 9 1977 | Audrey McCready |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 25M
(VR A 15 (4) ) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23257

1. DECEASED NAME (TYPE OR PRINT): FIRST Charles; MIDDLE L.; LAST Snyder

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR 10-25-77; 2b. HOUR 3a M

3. SEX: Male; 4. RACE: White; 5. DATE OF BIRTH MONTH DAY YEAR: Nov 8 1911; 6. AGE (IN YEARS. LAST BIRTHDAY) 65 YRS.; IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-25-77; 2d. HOUR ~~3~~ 4 lp M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland; 7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 91 Henderson Ave

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Employee; 12b. KIND OF BUSINESS OR INDUSTRY: Railroad

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland; 13b. COUNTY: Allegany; 13c. CITY OR TOWN: Cumberland; 13d. INSIDE CITY LIMITS? YES ☒ NO ☐; 13e. STREET ADDRESS: 91 Henderson Avenue

14. FATHER'S NAME FIRST Henry MIDDLE LAST Snyder

15. MOTHER'S MAIDEN NAME FIRST Georgia MIDDLE Marie LAST Bush

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. 217-18-4081

17. INFORMANT: Mrs. Helen Linkus; ADDRESS 2715 Daisy Avenue Baltimore, Md 21227

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — ———

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 10-25-77

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial; 23b. DATE: Oct 28/77; 23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Park; 23d. LOCATION CITY OR TOWN Cumberland COUNTY Allegany STATE Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: Silcox-Merritt, Cumberland, Maryland

25a. DATE REC'D. BY REGISTRAR: OCT 31 1977; 25b. REGISTRAR'S SIGNATURE: Tiffany McCready

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201**

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

77 2 3 2 5 7

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23258

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | MYRTLE M. TALLARITO | 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 16, 1977 |
| 2b. HOUR | 4:20 AM | | |
| 3. SEX | Female | 4. RACE | White |
| 5. DATE OF BIRTH MONTH DAY YEAR | 4 10 1893 | 6. AGE (IN YEARS LAST BIRTHDAY) | 84 YRS. |
| IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | W.Va. | 7b. CITIZEN OF WHAT COUNTRY? | U.S. of A. |
| 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | Allegany County MD. |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | MEMORIAL HOSPITAL |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | W.Va. | 13b. COUNTY | Hampshire |
| 13c. CITY OR TOWN | Romney | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS 252 W. Main St. |
| 14. FATHER'S NAME FIRST MIDDLE LAST | Joseph H. Newhouse | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | Belle Davis |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | NO | (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 236-14-7462 B | 17. INFORMANT | Joseph Tallarito ADDRESS 252 W. Main St., Romney W.Va. 26757 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Adeno CA of Colon c bone + liver

DUE TO, OR AS A CONSEQUENCE OF (c) metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1538

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Sept 20 19 77, to Oct 16 19 77, that (I) (we) last saw the deceased alive on Oct 15 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | | DEGREE MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | DR. TERRY WILLIAMS, MD. | 22e. ADDRESS | MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502 |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | Oct. 19, 1977 |
| 23c. NAME OF CEMETERY OR CREMATORY | Indian Mound | 23d. LOCATION CITY OR TOWN COUNTY STATE | Romney, Hampshire, W.Va. |
| 24. FUNERAL DIRECTOR NAME ADDRESS | Keith S. Shaffer; 230 E. Main St., Romney, W.Va. | 25a. DATE REC'D. BY REGISTRAR | Oct OCT 20 1977 |
| 25b. REGISTRAR'S SIGNATURE | Pat Kay McCready | | |

BP_____

DHMH - 16 60M 1/75
(VR A 15 (4))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23259

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Etta | E. | Thomas | 10 - 30 - 77 | 12:49 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Caucasion | 9 - 22 - 1897 | 80 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Allegany County; Frostburg, MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frostburg, MD | Frostburg Community Hospital | HOUSEWIFE | OWN HOME |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Allegany | Frostburg | YES ☒ NO ☐ | 13 South Grant Street |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| LOUIS | | Snyder | LAURA | | Porter |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | N.A. | 213-09-6616 | Beverley Thomas, Medical Records Director | Frostburg, MD |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial Infarction & Cardiac arrythmia | Few hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Thrombosis | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Hypertensive Vascular Disease | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

old age

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from — 19 75, to 10. 31 19 77, that (I) (we) last saw the deceased alive on 10. 31 19 77, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| S. Lal Sandhir MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| S. Lal Sandhir, M.D. | 48 Tarn Terrace; Frostburg, MD 21532 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 11/2/77 | FROSTBURG COMM. HOSP | FROSTBURG, ALLEGANY, MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SOWERS FUNERAL HOME | FROSTBURG, 60 W. MAIN ST., | NOV 7 1977 | Kathryn McCready |

Marilou M. Sowers

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

77 23260
REG. NO.

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| JAMES | WILLIAM | VIRTS | OCTOBER 16, 1977 | 1:30 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
| Male | White | April 25 1900 | 77 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | USA | | ALLEGANY COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cumberland | SACRED HEART HOSPITAL | Coal Miner | Coal Mines | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS | |
| W.Va. | Mineral | | | Box 31 Rt.2 Keyser, W.Va. | |
| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
| William | H. | Virts | Mary | | Herman |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | |
| no | | 219 03 8361 | Anna Staggs | Rt.2 Keyser, W.Va. 26726 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF PROSTATE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MONTHS
185X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| | | | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Oct - 16 19 16 to Oct - 16 19 77, that (I) (we) last saw the deceased alive on 10/16 19 77 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M. Montgomery — DEGREE: M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 10/17/77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. MONTGOMERY M.D.

22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD 21502

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | |
| Burial | Oct. 19, 1977 | Potomac Memorial Garden | Keyser | Mineral W.Va. |
| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| BOALS FUNERAL HOME | Westernport, Md. | OCT 20 1977 | Tiffany McCurdy | |

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

77 2 3 2 5 0

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

77 23261
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST MIDDLE LAST: JAMES RUSSELL WAGNER
2a. DATE OF DEATH — MONTH DAY YEAR: OCTOBER 14, 1977
2b. HOUR: 11:55AM
3. SEX: Male
4. RACE: Cau
5. DATE OF BIRTH — MONTH DAY YEAR: Aug 23 1898
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. — IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH:
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 208 Maryland Ave.

14. FATHER'S NAME — FIRST MIDDLE LAST: James K. Wagner
15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: Annie Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes
(IF YES, GIVE WAR OR DATES): WWII
16b. SOCIAL SECURITY NO.: 214-05-8234
17. INFORMANT: Edgar Wagner
ADDRESS: Bro. Meyersdale, Pa. 15552

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchogenic epidermoid carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unk
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: appox 10/7/77
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Biopsy of Tumor
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/2/77, 19____, to 10/14/77, 19____, that (I) (we) last saw the deceased alive on 10/13/77 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: A. Bollino M.D.
DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 14 Oct 77
22d. PHYSICIAN'S NAME (TYPE OR PRINT): A. BOLLINO, M.D.
22e. ADDRESS: 500 MEMORIAL AVENUE, MEDICAL BLDG. CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10/17/77
23c. NAME OF CEMETERY OR CREMATORY: Union
23d. LOCATION — CITY OR TOWN: Meyersdale COUNTY: Som. STATE: Pa.
24. FUNERAL DIRECTOR — NAME: LECKEMBY FUNERAL HOME — ADDRESS: MEYERSDALE, PA.
25a. DATE REC'D. BY REGISTRAR: OCT 26 1977
25b. REGISTRAR'S SIGNATURE: Tiffany McCready

BP____

DHMH - 16 50M 1/76
(VR A 15 (4))

77 2525 1

JAMES RUSSELL LAGNER OCTOBER 14, 1977 11:55AM

ALLEGHENY COUNTY

SACRED HEART HOSPITAL

A. BOLLING, M.D. 500 HENDRIX AVENUE, MEDICAL BLDG.
CUNNINGHAM, MO. 21502

HOME BEVERSDALE, PA.

LOCKENBY FUNERAL

Items 5 and 6 gs17 5/9/78 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23262

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Charles R. Welling | 2a. DATE OF DEATH KNOWN / ESTIMATED — MONTH DAY YEAR | Oct. 25 1977 | 2b. HOUR | 11:30 P M |
| 3. SEX | Male | 4. RACE | White | 5. DATE OF BIRTH MONTH DAY YEAR | Mar. ~~21~~, ~~1904~~ 1905 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | ~~73~~ 72 YRS. | IF UNDER 1 YR.: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR | Oct. 25, 1977 | 2d. HOUR | 11:30 P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Md. | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Allegany MD. | | | | |
| 10. CITY OR TOWN OF DEATH | Cumberland | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Memorial DOA | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Ret. Engineer |
| 12b. KIND OF BUSINESS OR INDUSTRY | Rail Road | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md. | 13b. COUNTY | Allegany | 13c. CITY OR TOWN | Cumberland |
| 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | | 13e. STREET ADDRESS | 13001 McMullen Hwy. | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Charles R. Welling | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Martha Griffen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 214-07-5820 |
| 17. INFORMANT ADDRESS | Mrs. Charles R. Welling Cumberland Md. | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis, generalized — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

1538

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: 1975 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Resection of Colon | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED Oct. 26, 1977

EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M. D. ADDRESS RT. #9, Cumberland, Md. 21502

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | |
| Burial | Oct. 28, 1977 | Oakland Cemetery | Oakland Garrett | Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | William G. Kight Cumberland, Md. | 25a. DATE REC'D. BY REGISTRAR | NOV 1 1977 | 25b. REGISTRAR'S SIGNATURE Tiffany McCready |

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 1/75
(VR A 15 (4))

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 77 23263

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | BROSIE R. WHETZEL | 2a. DATE OF DEATH MONTH DAY YEAR | OCTOBER 21, 1977 |
| 2b. HOUR | 7:05 M | | |
| 3. SEX | Male | 4. RACE | White |
| 5. DATE OF BIRTH MONTH DAY YEAR | May 5 1897 | 6. AGE (IN YEARS LAST BIRTHDAY) | 80 YRS. |
| IF UNDER 1 YEAR: MONTHS DAYS | | IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | WV | 7b. CITIZEN OF WHAT COUNTRY? | USA |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | | 9. BALTIMORE CITY OR COUNTY OF DEATH | Allegany MD. |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | MEMORIAL HOSPITAL |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Ret. | 12b. KIND OF BUSINESS OR INDUSTRY | Tire Co. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | MD | 13b. COUNTY | Allegany |
| 13c. CITY OR TOWN | Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | |
| 13e. STREET ADDRESS | 107 ½ Blaul Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | Noah Whetzel | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | Florena Dove |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 224-16-9647 | 17. INFORMANT | Louella Bean |
| ADDRESS | Cumberland, MD | Daughter | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma of Pancreas. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) —

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 10-14-77 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | Exploratory laparotomy. |
| 20a. AUTOPSY? YES ☐ NO ☒ | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10/16/77, 19____, to 10/21, 19 77, that (I) (we) last saw the deceased alive on 10/21/19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Mathew N.A. Ranjitham MD, ABIM (for Dr Druger) | DEGREE | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ |
| 22c. DATE SIGNED | 10/22/77 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | DR. GEORGE DRUGER | 22e. ADDRESS | MEMORIAL MEDICAL BLDG, CUMBERLAND, MD |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 10-24-77 | |
| 23c. NAME OF CEMETERY OR CREMATORY | Sunset Memorial Park | 23d. LOCATION CITY OR TOWN | Cumberland | COUNTY Allegany STATE MD |
| 24. FUNERAL DIRECTOR NAME | James F. Scarpelli | ADDRESS | Cumberland, MD | |
| 25a. DATE REC'D. BY REGISTRAR | OCT 26 1977 | 25b. REGISTRAR'S SIGNATURE | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 77 23264

1. DECEASED NAME (TYPE OR PRINT): First: Roy; Middle: ; Last: Wise

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Month Day Year: 10-28-77

2b. HOUR: 9p M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH Month Day Year: Aug. 21, 1911

6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD Month Day Year: 10-28-77

2d. HOUR: 11:30p

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital---DOA

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: State Roads

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Rt.#4 Box ☒ 322

14. FATHER'S NAME First Middle Last: Lemeul Wise

15. MOTHER'S MAIDEN NAME First Middle Last: Lillian Link

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220 10 4604

17. INFORMANT ADDRESS: Edith Wise, as above

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Benedict Skitarelic TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 10-28-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M.D. ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/31/77

23c. NAME OF CEMETERY OR CREMATORY: Glendale Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Allegany Co. Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: John J. Hafer, Jr., LaVale, Maryland

25a. DATE REC'D. BY REGISTRAR: NOV 4 1977

25b. REGISTRAR'S SIGNATURE: Kathryn McCurdy

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201**

BP

DHMH - 17
(VR A15 ME(5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23265

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Gertrude S. — MIDDLE: — LAST: Woerner

2a. DATE OF DEATH — MONTH DAY YEAR: Oct. 2, 1977

2b. HOUR: 3P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: Dec. 29, 1888

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 721 Lafayette Ave.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 721 Lafayette Ave.

14. FATHER'S NAME — FIRST: John — MIDDLE: S. — LAST: Kessel

15. MOTHER'S MAIDEN NAME — FIRST: Belle — MIDDLE: Bobo — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 218-60-0287

17. INFORMANT — ADDRESS: Mrs. Freda Foley, Greenspring, W.Va. Daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: One year

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of the breast

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from August 19, 19 77, to October 2, 19 77, that (I) (we) last saw the deceased alive on October 2, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: G. Overton Himmelwright, M.D. — DEGREE: M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10-4-77

22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. Overton Himmelwright, M.D.

22e. ADDRESS: 133 Virginia Ave., Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10-5-1977

23c. NAME OF CEMETERY OR CREMATORY: Lehmansville Cemetery

23d. LOCATION — CITY OR TOWN: Lehmansville — COUNTY: W. Va. — STATE:

24. FUNERAL DIRECTOR — NAME — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. DATE REC'D. BY REGISTRAR: OCT 7 1977

25b. REGISTRAR'S SIGNATURE: Tiffany McCready

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23266

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Jesse | Edward | Wolford | October 30, 1977 | 12:30 A.M. M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | Jan. 22 1906 | 71 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| WV | US of A | | Allegany MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Retired | City of Cum. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| MD | Allegany | Cumberland | YES ☒ NO ☐ | 50 Blackiston Avenue |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| John E. | | Wolford | Lona | | Wolford |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs. Mary Ann Goetz | Cumberland, MD |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial failure | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Severe Parkinson's Disease | yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Diabetes Mellitus | yrs |

342x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from MAR 1969 to 10/30 1977, that (I) (we) last saw the deceased alive on 10/29 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| George M. Simons M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☒ | 10/31/77 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| George M. Simons, M. D. | Memorial Hospital Cumberland, Md. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11-1-77 | Hillcrest Burial PK. | Cumberland / Allegany / MD |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| James F. Scarpelli | Cumberland, MD | NOV 7 1977 | Audrey McCready |

DHMH-16 60M 1/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23267

1. DECEASED NAME (TYPE OR PRINT): FIRST Donald MIDDLE Wesley LAST Wood

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 10 DAY 26 YEAR 77 — 2b. HOUR 6:50 PM

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 02 DAY 17 YEAR 45 — 6. AGE (IN YEARS LAST BIRTHDAY): 32 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 26 YEAR 77 — 2d. HOUR 6:50 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital----DOA — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Contract Driver — 12b. KIND OF BUSINESS OR INDUSTRY: Moving

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY — 13c. CITY OR TOWN: Baltimore — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 3619 Roland Avenue

14. FATHER'S NAME: FIRST William MIDDLE Wood LAST — 15. MOTHER'S MAIDEN NAME: FIRST Maude MIDDLE Kelley LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 213 44 8838 — 17. INFORMANT: Starr Wood — ADDRESS: 3619 Roland Avenue 21211

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Compression of Chest — "
DUE TO, OR AS A CONSEQUENCE OF (c): (under overturned truck)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. 4:50 P.M. MONTH 10 DAY 26 YEAR 77 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Passenger in overturned truck

21d. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE: Rt.#40, One mile East of Flintstone, Allegany, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 10-26-77

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M.D. — ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 31 Oct. 77 — 23c. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Park — 23d. LOCATION CITY OR TOWN COUNTY STATE: Baltimore Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: James F. Scarpelli, Cumberland, Md. — 25a. DATE REC'D. BY REGISTRAR: NOV 1 1977 — 25b. REGISTRAR'S SIGNATURE: Kathryn McCready

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

1326 BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 77 23268

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | BABY BOY YORK | 2a. DATE OF DEATH MONTH / DAY / YEAR | 10 / 13 / 77 | 2b. HOUR | 2055HRS |
| 3. SEX | MALE | 4. RACE | NEGRO | 5. DATE OF BIRTH MONTH / DAY / YEAR | 10 / 13 / 77 |
| 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS 20 / MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | Infant |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | Allegany MD. | | | | |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND, MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | MEMORIAL HOSPITAL, CUMBERLAND, MD. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | D.C. | 13b. COUNTY | | 13c. CITY OR TOWN | Washington |
| 13d. INSIDE CITY LIMITS? | YES ☒ NO ☐ | 13e. STREET ADDRESS | S.E. Congress St. | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Luvernie Elizabeth York | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 7750 Prematurity

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Rh Factor

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | — |
| 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ | | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | I.B. Ackles | DEGREE | M.D. |
| ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED | 10/14/77 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Dr. I.B. Ackles | 22e. ADDRESS | Memorial Hospital |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Cremation | 23b. DATE | 10/15/77 | 23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital |
| 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Cumberland Allegany Md. | | | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | | 25a. DATE REC'D BY REGISTRAR | OCT 19 1977 | 25b. REGISTRAR'S SIGNATURE |

DHMH - 16 50M 1/76
(VR A 15 (4))